HOSPITAL Topics

GRAPHIC REPORTING ON TODAY'S HOSPITAL PRACTICES

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Third-Party Payors
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Infections of the Newborn
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PAUL G. FINNMAN (see page 3)

BUYER'S GUIDE Page 52

NOVEMBER 1 1957

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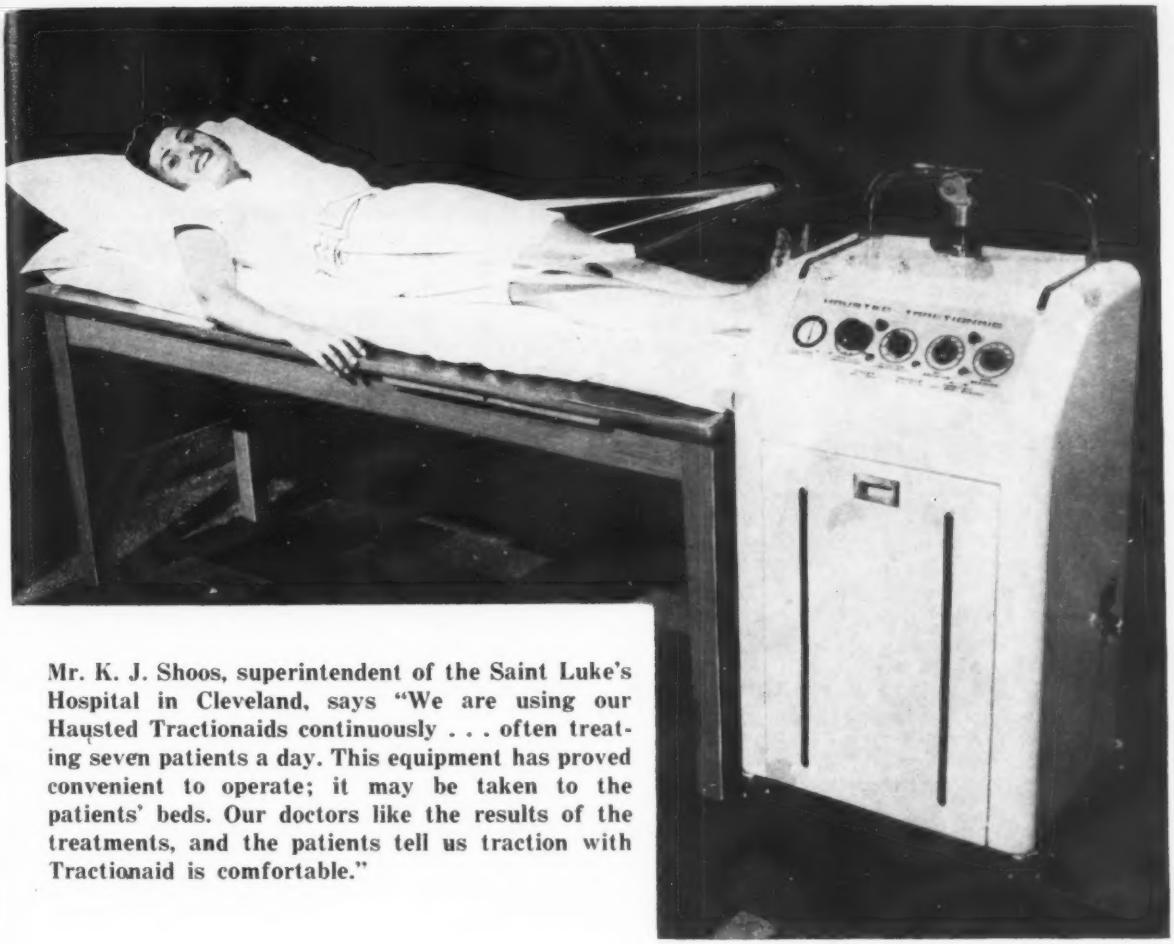

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HOSPITAL Topics

GRAPHIC REPORTING ON TODAY'S HOSPITAL PRACTICES

NOVEMBER, 1957, VOL. 35, NO. 11

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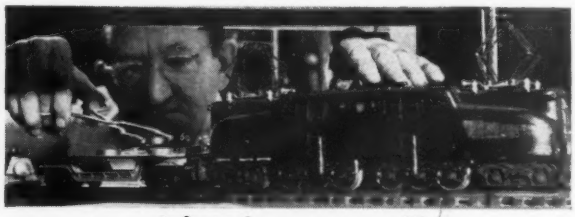

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PERSONALITY OF THE MONTH

PAUL G. FINNMAN, administrator, North Platte (Nebr.) Memorial Hospital, is firmly convinced of the need for more chronic care units in connection with hospitals, to reduce the cost of such care and yet have hospital facilities easily accessible when they are needed. It is quite logical, consequently, for the 46-bed North Platte hospital to have a home for aged invalids and the chronically ill—the only facility of its kind in Nebraska, outside of Omaha. It accommodates 38 persons.

The unit is housed in the old hospital building, which was renovated and remodeled after the new, air-conditioned hospital opened in July, 1956. A corridor connects the two buildings, and occupants of the home receive any necessary hospital tests or therapy on an outpatient basis.

Mr. Finnman was co-director of the fund-raising drive for the new hospital, which started soon after he became administrator in August, 1953. The campaign culminated in a radio marathon appeal over local station KODY, during which 500 donors to the "$100 Club" were secured in four and one-half hours.

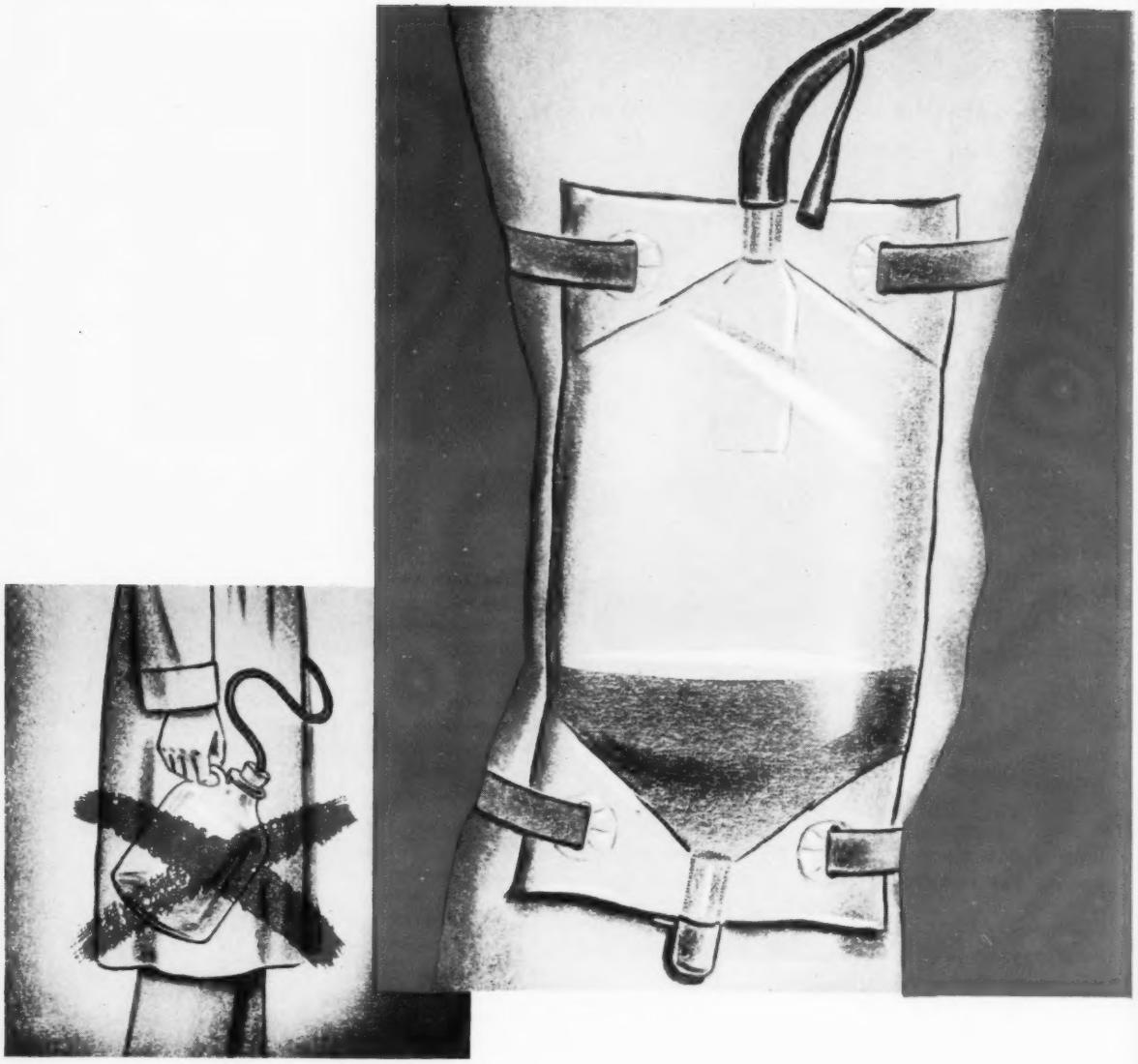
An organist since he was 13 years old, Mr. Finnman plays every day for patients and personnel, on a portable electric organ donated by the hospital anesthetist. The hospital plans to purchase a public-address system within the next few months, so that the music may be carried simultaneously to all rooms in the hospital and the home.

A past vice-president and past secretary, Nebraska Hospital Association, Mr. Finnman is a member of the board of directors, Nebraska Blue Cross, and the board of trustees, Mid-West Hospital Association. Active in community affairs, he is a member of the board of directors of the North Platte Community Chest and the North Platte Kiwanis Club, of which he is vice-president.

Before accepting his present position, Mr. Finnman was employed by Immanuel Hospital, Omaha, from 1940-53, as business manager and assistant treasurer. From 1942-46, he served in the Army in an administrative capacity.

He received a B.A. degree in business administration from Augustana College, Rock Island, Ill., and is the composer of his school's Alma Mater song.

Mr. Finnman met his wife, Esther, at Immanuel Hospital, where she was a student nurse. They have three sons: David, 10; Danny, 7; and Douglas, 4. North Platte's administrator enjoys sports and working with youth in both sports and scouting work. He was a Little League baseball manager during the 1957 season.



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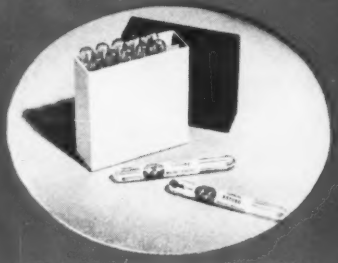

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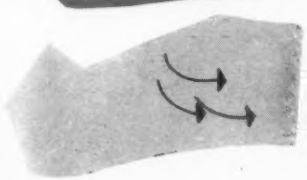

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*'*A.S.A. Compound*' (*Acetylsalicylic Acid and Acetophenetidin Compound, Lilly*)
1. *Gruber, C. M., Jr.: J. A. M. A.*, 164:*966* (*June 29*), *1957.*

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720221

HOSPITAL Topics
The News Magazine for the Hospital Staff

NOVEMBER, 1957
VOL. 35, NO. 11

Scanning the News

Emotional Patterns Charted in Diagnosing Mental Ills

The relationship between emotions and mental illness is being measured by a VA research group.

Using electrical apparatus to record hidden physical responses to emotional situations, the group, headed by Luther L. Mays, Ph.D., chief psychologist, VA Hospital, Washington, D.C., and Harold F. Corson, M.D., chief psychiatrist at the hospital, plots emotional reactions in terms of bodily changes.

The main instrument used in testing mental patients is a polygraph, which makes readings from six areas of the body. The patient relaxes in a darkened room and listens to recorded music alternately soothing and rousing. He is then questioned concerning general living problems. The answers are tape-recorded, and at the end of the test, which takes 30 minutes, a strip of graph paper gives the picture of his emotional responses.

Data is combined with information obtained from standard diagnostic tests and clinical observation by the doctors. From this material, a chart is prepared for each patient, showing his emotional pattern and behavior.

More than 62,000 people jammed Long Island's Roosevelt Raceway September 8 for the seventh Hospital Star Nite, produced this year by Mike Todd for the Long Island Industry Labor Fund for Hospitals. Huge cast of big-name entertainers highlighted benefit performance, held annually to finance expansion programs in 20 Long Island nonprofit hospitals. Feature of afternoon circus-variety show was ascent by Eddie Fisher and Todd in balloon used in movie "Around the World in 80 Days." Proceeds from performances and corporation pledges this year totaled almost $500,000, according to fund officials.

WHO Approves Fluoridated Drinking Water

The World Health Organization has asserted that use of fluoridated drinking water to prevent tooth decay is safe, effective, and practical.

After studying hundreds of fluoridation programs in 17 countries, an expert committee of the United Nations Health Agency in Geneva, Switzerland, reported that fluorine added to drinking water was approved by responsible public health officials throughout the world.

In the U.S., 32,000,000 in more than 1,500 communities are drinking fluoridated water, according to WHO. Sixteen other countries have begun similar programs.

The committee stated that results in all nations using fluoridated drinking water showed remarkable uniformity. Dental decay in permanent teeth of children was found to have decreased by about 60 percent, and in primary teeth, from 50 to 60 percent. The children also had well-formed teeth, more resistant to caries.

Adults living in areas where fluorides are found naturally in drinking water were subject to about two-thirds fewer cases of tooth decay.

Use of water containing 1 part of fluorine for 1,000,000 parts of drinking water was recommended.

Deranged Metabolism Called Cause of Alcoholism

A cure for alcoholism may be found through nutritional adjustment, Roger J. Williams, Ph.D., told the American Chemical Society at its recent national meeting in New York.

Work done in this field at the University of Texas Biochemical Institute has led him and his associates to believe they have found the biochemical basis of alcoholic craving, and possibly a method for its prevention or abolition.

Dr. Williams is director of the institute. Studies there have indicated that a deranged metabolism of the hypothalamus may account for a tendency to alcoholism. He termed the hypothalmus the "appetite regulating center" and said that research shows an alcoholic's urge to drink is similar to the normal urge to eat food and drink water.

Dr. Williams said evidence showed that, in alcoholics, the appetite regulating center becomes malnourished, and as a result, becomes easily poisoned by alcohol or its metabolic products. It has been found, he said, that in alcoholics, the nutritional needs of the hypothalamus are unusual.

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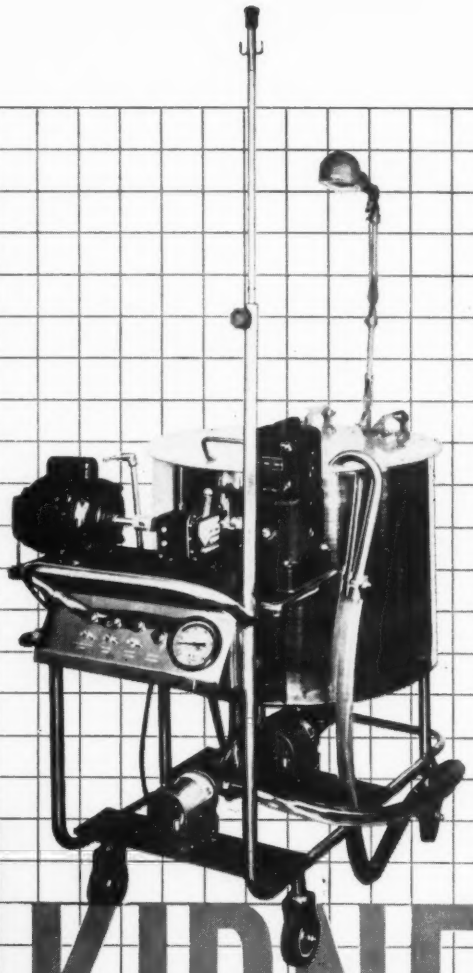
a practical, disposable



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INDICATIONS:

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News Briefs at Press Time

STOCK MARKET IN READJUSTMENT PERIOD; PRODUCTION MUST REMAIN HIGH

In response to many inquiries regarding the present business pessimism reflected by the stock-market decline, HOSPITAL TOPICS has conducted its own survey.

Methods used included discussion with bankers and brokers, interviews with officials of the New York and American Stock Exchanges, and questionnaires sent to managers of large institutional portfolios. The consensus is that:

—The present unsettled condition is a "shake-out"—a short-term readjustment.

—Russia's apparent advantage in guided missiles is an assurance that the cold war will continue unabated. This means that production must remain high.

—Institutional and other large investors have not been liquidating, but have actually been doing more buying than selling. There have been some changes in holdings, with some selling in aircraft industries and strictly consumer corporate holdings.

—Tight money will continue for at least three months. It will be eased up only when building costs and the Bureau of Labor Statistics cost-of-living index decline (the latter at least five points).

Look for building costs to fall off in next 30-60 days. Labor Department reports unemployment in building trades in many areas—for the first time since before the Korean War.

Nurse recruitment may be aided by some of changes predicted above. Nurses whose husbands have been making big money by drawing overtime pay are returning to hospitals, as industries curtail overtime hours.

NEW YORK INSURANCE PROGRAM SOON TO GO INTO EFFECT

An insurance program soon to become effective in New York State will provide liberal hospitalization, surgical, and in-hospital medical benefits for some 70,000 active, and an additional 7,000 retired state employees, plus dependents.

Employees deciding to participate will have wide choice of plans—including Blue Cross, Blue Shield, and group practice care. Their share of cost will depend on type of coverage selected and whether dependents are included.

COMMITTEE ADVISES AGAINST WIDE USE OF BCG VACCINATION

A special advisory committee to PHS has issued a report advising against large-scale use of BCG vaccination for TB.

Reasons given by the committee for its recommendation were: (1) BCG vaccination offers no protection to persons already infected; (2) it would impede case-finding, since it converts tuberculin nonreactors into reactors; (3) its adoption would divert personnel and funds from other TB control activities, and (4) it might lead to a false sense of security and disregard of precautions that should be taken.

Immunization might well be limited, said the report, to doctors and paramedical personnel who risk exposure to TB, persons exposed to infectious cases in the home, and employees, patients, and inmates of prisons and institutions having a comparatively high case rate.

Members of the advisory committee of Research Foundation, on the other hand, reported recently (Journal of the American Medical Association 164:951-54) that BCG vaccination is safe and effective and would aid materially in controlling TB in regions of high incidence. They recommended vaccination of infants and children in areas of high incidence and revaccination at suitable intervals (see HOSPITAL TOPICS, August, 1957, page 87).

BRIEF BRIEFS

First National Conference on Nursing Homes and Homes for the Aged will be held in Washington, D. C., February 25-28, 1958 . . . Federal bureaus will now be permitted to advertise for medical, biological, and other scientists in professional and trade journals and in college publications, and also in daily newspapers, in connection with local procurement campaigns. Satellite Sputnik deserves credit for the lifting of the long-time advertising ban.

Gordon M. Marshall

Calendar of Meetings

NOVEMBER

4- 5 Oregon Association of Hospitals, Eugene Hotel, Eugene

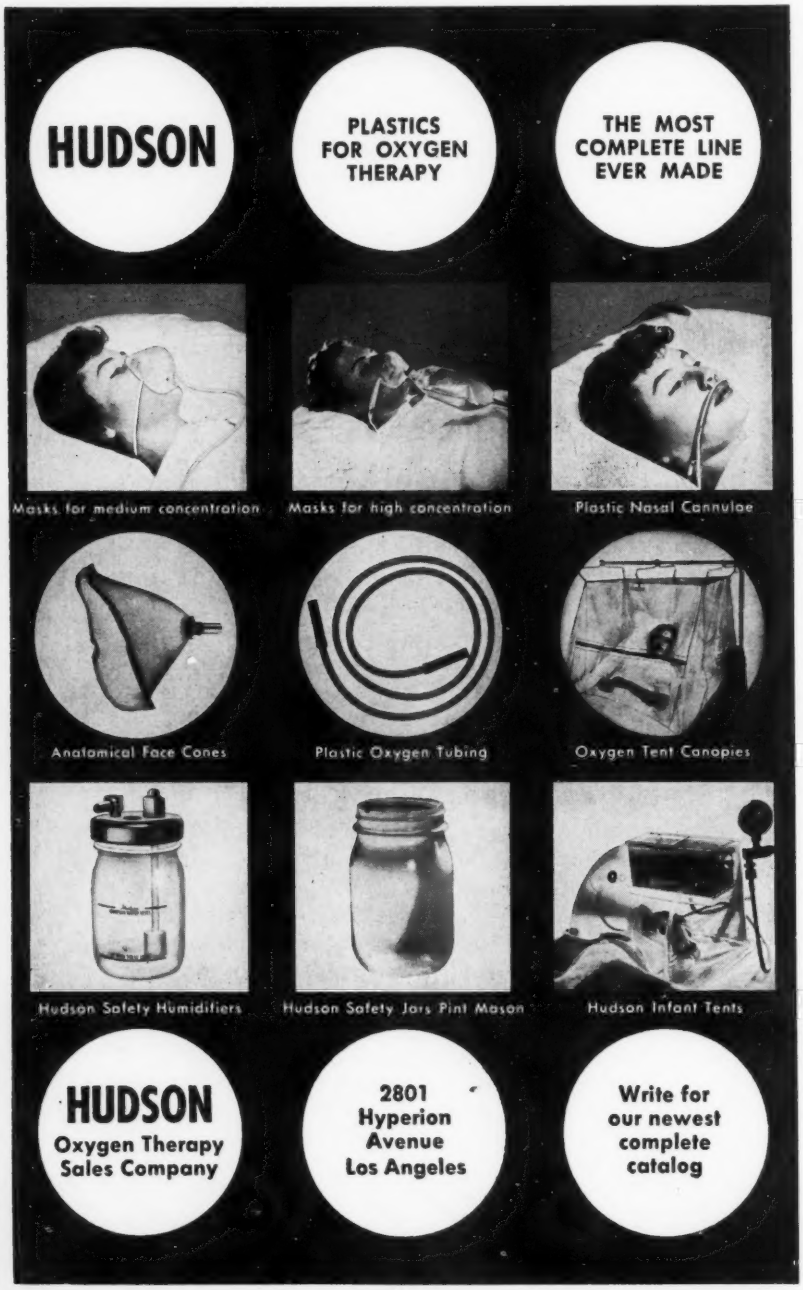
4- 6 American Association of Blood Banks, Hotel Sherman, Chicago

4- 8 American Association of Inhalation Therapists, Hollender Hotel, Cleveland

6- 7 Washington State Hospital Association, Olympic Hotel, Seattle

6- 8 Maryland-District of Columbia-Delaware Hospital Association, Hotel Shoreham, Washington, D.C.

7- 8 Oklahoma Hospital Association, Mayo Hotel, Tulsa



11 American Hospital Association Institute, Housekeeping, King Edward Hotel, Toronto, Ont.

11 American Hospital Association Institute, Medical Record Library Personnel, Sheraton-Plaza Hotel, Boston

11 American Hospital Association Institute, Nursing Service Administration, Princess Kaiulani Hotel, Honolulu

11-15 American Public Health Association, Auditorium, Cleveland

13 Connecticut Hospital Association, Conn. Light & Power Co., Berlin

14-15 Kansas Hospital Association, Broadview Hotel, Wichita

14-22 Seventh Congress, Pan-Pacific Surgical Association, Hawaiian Village Hotel, Honolulu

14-16 Virginia Hospital Association, Hotel Chamberlin, Old Point Comfort

17-22 Radiological Society of North America, Palmer House, Chicago

18 American Hospital Association, Seventh Hospital Institute, Reese Hotel, Honolulu, Hawaii

18-22 Pan American Medical Association, Mexico City

18-22 American College of Hospital Administrators, New England Institute, Somerset Hotel, Boston

18-22 American Hospital Association Workshop on Operating Problems for Small Hospitals, Texas; Amarillo, 18; Abilene, 19; Dallas, 20; College Station, 21; Corpus Christi, 22

21-23 National Association for Mental Health, Annual Meeting, Shelburne and Dennis Hotels, Atlantic City

DECEMBER

2- 6 American College of Hospital Administrators, Advanced Institute, Ambassador Hotel, Los Angeles

3- 6 American Medical Association (Clinical Meeting), Commercial Museum, Philadelphia

5 Institute on Heart Disease, Monterey County and California Heart Associations, U.S.O., Salinas, Calif.

5- 6 Illinois Hospital Association, Hotel Abraham Lincoln, Springfield

5- 6 Arizona Hospital Association, Hotel Westward Ho, Phoenix

(Continued on page 15)

IN
—uterine inertia—primary and secondary
—third stage of labor
—postpartum hemorrhage due to uterine atony

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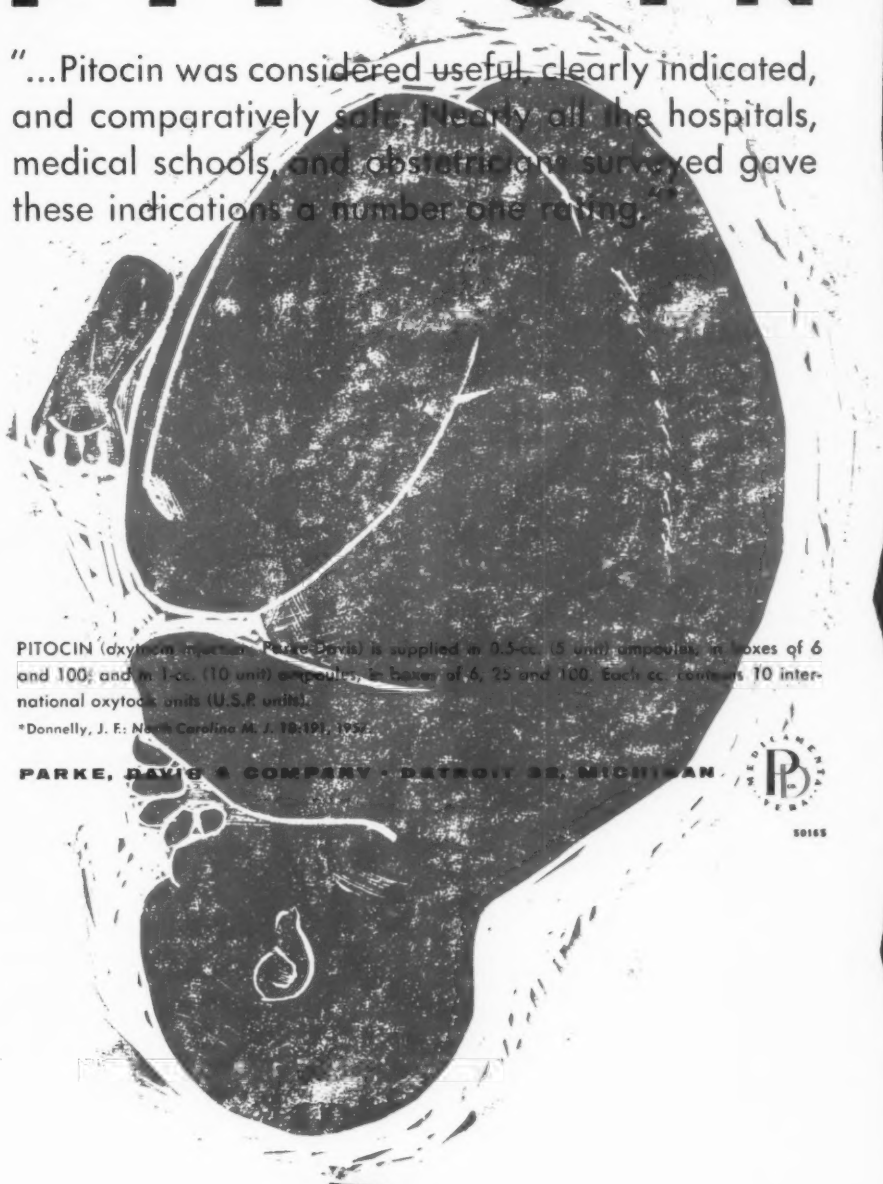

PITOCIN (oxytocin injection, Parke, Davis) is supplied in 0.5-cc. (5 unit) ampoules, in boxes of 6 and 100; and in 1-cc. (10 unit) ampoules, in boxes of 6, 25 and 100. Each cc. contains 10 international oxytocic units (U.S.P. units).

*Donnelly, J. F.: North Carolina M. J. 18:191, 1957.

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The many thousands of patients successfully treated with Signemycin* over the past year have confirmed the value of this safe and effective antibiotic agent. One further therapeutic resource is thereby provided the practicing physician who is faced daily in office and home practice with immediate diagnosis of common infections and the immediate institution of the most broadly effective therapy at his command, in his continuing task of the ever-extending control over human pathogens.

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"Eighty-seven patients with various infections of the skin were treated over a period of six weeks with [Signemycin]. Excellent or good results were achieved in sixty-seven, including eleven of twenty-two patients refractory to other antibiotics."

Lewis, H. H.: Frumess, G. M., and Honschel, E. J.: Rocky Mountain M. J. 54:806 (Aug.) 1957.

"Results of treatment with oleandomycin-tetracycline of 50 infections [mostly respiratory] due to resistant organisms and 40 infections [respiratory, skin, urinary infections] due to sensitive organisms are very encouraging. In some of these patients, [Signemycin] was lifesaving, and in others surgery was made unnecessary. This confirms other reports."

Shulein, H.: Antibiotic Med. & Clin. Therapy 4:174 (March) 1957.

Based on case reports documented by independent investigators in 26 countries abroad, the clinical response obtained with Signemycin in 1404 patients with a wide variety of infections was successful in 1329 patients; in 13 cases only was it necessary to discontinue therapy because of side effects.

Report on 1404 Cases Treated with Signemycin: Medical Department, Pfizer International. Available on request.

In 50 nonselected patients, Signemycin "...appears to be effective in the treatment of most general surgical infections, including virulent staphylococcus aureus infections. In some cases these infections had been clinically resistant to other antibiotics. The drug is apparently well tolerated."

Levi, W. M., and Kredel, F. E.: J. South Carolina M. A. 53:178 (May) 1957.

Of 50 patients with various infectious processes, 26 had not responded to previous antibiotic therapy. With Signemycin "Ninety-six per cent of the mixed infections were clinically controlled. . . . and in none of the cases was there any reason to discontinue the drug."

Winton, S. S., and Chesrow, E.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 55.

Signemycin in 79 patients with severe soft tissue infections: "The average response of these cases was excellent and inflammatory symptoms subsided with almost uniform rapidity....The magnitude and incidence of surgical intervention was reduced....Side reactions were minimal. . . ."

LaCaille, R. A., and Prigot, A.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 67.

Five groups of patients (total 211) with acne were treated with one of five antibiotic agents, including Signemycin (55 cases). "The results were evaluated taking into consideration the usual response to such conservative conventional therapy and the rapidity of response." In 8 weeks, Signemycin rapidly attained and maintained the highest percentage of efficacy of antibiotic agents tried.

Frank, L., and Stritzler, C.: Antibiotic Med. & Clin. Therapy 4:419 (July) 1957.

In the treatment of 78 patients with tropical infections, some complicated by multiple bacterial contamination or present for years, Signemycin was found to be "...an exceptionally effective agent," requiring smaller doses and less extended periods of therapy than with the tetracyclines alone, and "caused no notable toxic reactions."

Loughlin, E. H., and Mullin, W. G.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 63.

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CALENDAR OF COMING EVENTS

(Continued from page 10)

7-12 American Academy of Dermatology and Syphilology, Palmer House, Chicago

26-31 American Association for Advancement of Science, Murat Temple, Indianapolis

JANUARY 1958

13-17 Fellows' Seminar, American College of Hospital Administrators Institute, University of North Carolina, Chapel Hill

15-17 Association of Western Hospitals, Institute on Nursing Education, Sir Francis Drake Hotel, San Francisco

20-24 Southern American College of Hospital Administrators Institute, Jackson, Miss.

30-31 Alabama Hospital Association, Hotel Stafford, Tuscaloosa

FEBRUARY 1958

7- 8 American Hospital Association, Mid-year Conference of Presidents and Secretaries of State and Regional Hospital Associations, Palmer House, Chicago

9-11 Congress on Administration, American College of Hospital Administrators, Congress Hotel, Chicago

10-13 Association of Operating Room Nurses, Bellevue-Stratford Hotel, Philadelphia

11-13 National Association of Methodist Hospitals and Homes, Morrison Hotel, Chicago

17-21 1st Eastern Advance Institute, American College of Hospital Administrators, New York City

17-21 Minnesota Institute, American College of Hospital Administrators, Minneapolis

20-21 Georgia Hospital Association, Ralston Hotel, Columbus, Ga.

MARCH

10-13 Ohio Hospital Association, Netherland-Hilton Hotel, Cincinnati

13-15 Tennessee Hospital Association, Hotel Patton, Chattanooga

24-26 Mid-West Hospital Association, Municipal Auditorium, Kansas City, Mo.

24-26 New England Hospital Assembly, Hotel Statler, Boston

24-27 Congress of the International Anesthesia Research Society, Jung Hotel, New Orleans, La.

APRIL

15-17 Kentucky Hospital Association, Sheraton-Seelbach Hotel, Louisville

21-24 Association of Western Hospitals, St. Francis Hotel, San Francisco

24-25 Carolinas-Virginias Hospital Conference, Hotel Roanoke, Roanoke, Va.

28-30 Tri-State Hospital Assembly, Palmer House, Chicago

MAY

5- 8 Annual Convention, Texas Hospital Association, Statler Hilton Hotel, Dallas

14-16 Southeastern Hospital Conference, Hotel Fountainebleau, Miami Beach, Fla.

25-31 World Congress of Gastroenterology, Sheraton-Park Hotel, Washington, D. C.

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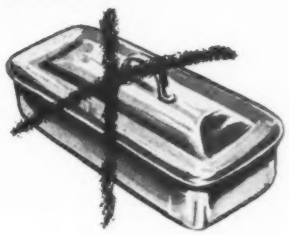

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1 **Collect blood** The PLIAPAK collects blood by gravity, using a closed system which is virtually airfree. The bag fills gently, expanding to admit the blood without foaming or turbulence. A collection set is included, with plastic tubing and siliconed needle, providing a completely nonwettable blood path.

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5 **Infuse blood** No air is admitted; the bag simply collapses as it is evacuated. Thus a potential source of air embolism is eliminated, and any air-borne contaminants are excluded. In emergencies the attendant can instantly force blood into the vascular tree without additional apparatus, simply by squeezing the bag, or by slipping it under the recipient's shoulders or buttocks. The PLIAPAK accepts any standard administration set, including series and alternating hookups. Abbott

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COMING IN HOSPITAL Topics

A new series by Louis Block, Dr. P.H., author of HOSPITAL TRENDS, giving statistics on hospitals in each major region of the United States, and showing how the regions fit into the national picture, on the following topics: number of hospitals, number of beds, daily adult census, admissions, number of bassinets, daily newborn census, number of births, total assets, plant assets, total expenses, payroll, and full-time personnel.

More in the series by John H. Gorby on all aspects of hospital administration. These concisely written articles provide an up-to-date manual on hospital operation. Among departments to be discussed during 1958: nursing, pharmacy, central sterile supply, operating room, maintenance, dietary, laundry, housekeeping.

How to Set Up a Radioisotope Laboratory
Uses of Ultra-Sound in the Hospital
How a State Patient Care Commission Functions
Health Education in the Hospital

Symposium on Physical Therapy Departments: Need for the PT Department in the Hospital, Financial Benefits to the Hospital, and Solution to Financial Problems of the Department in a Small Hospital.

What a Therapeutics Committee Accomplished in Its First Year
Specific and helpful answers to your individual questions--
by John G. Steinle, TOPICS' consulting editor-- in
"Consultant's Corner"

Answers to your accounting problems--by David H. Tarlow, C.P.A.
Analysis of the latest court decisions affecting hospitals--by Leo T. Parker, in "Review of Hospital Lawsuits".

"Capsule coverage" of the top hospital, medical, surgical, and nursing association conventions, in the "Administrator's Digest". If you can't get away to a meeting, do the next best thing...read the report in TOPICS.

... plus timely, helpful articles every month in these departments: the Operating Room, Obstetrical Nursing, Pediatrics, The Lab, and Central Supply. Why not order additional subscriptions for these important departments?

Catherine Stein Koetler, assistant to the executive secretary, Catho.ic Hospital Association, St. Louis; John T. Kelly, legislative attorney, Washington office, AHA, and Msgr. Donald McGowan, director, Bureau of Health and Hospitals, Catholic Welfare Council, Washington, D. C., stroll down the boardwalk in Atlantic City between meetings at convention hall.

AHA Convention Report - Part II

HOSPITAL TOPICS presents here the concluding portion of its report on the highlights of the 1957 AHA convention in Atlantic City. Part I of the report appeared in the special insert, October issue. Additional technical exhibit coverage starts on page 59 of this issue.

Point Rating Most Objective Method of Job Classification

Outside Consultant Recommended For Development of Program

Point rating is the most precise and most objective method of job classification and evaluation. Following the preparation of job descriptions, factors for measuring job value are identified and defined. Point values are assigned to degree definitions under each factor. The factors can be weighed by varying the values assigned to each.

Conversion of total point values to salary ranges is accomplished by plotting total point scores and fitting a trend line to the scatter diagrams. The total range of possible point scores is divided into grades, and salary ranges are established by setting minimum and maximum rates 15 percent below and above the trend line.

Subjective ranking consists of the ranking of jobs in a particular occupation or department on the basis of a knowledge of their over-all difficulty and responsibility.

Factor comparison is a system in which the job elements for which salaries are paid are identified and monetary values are assigned to defined units of such elements. The salary rate, thus, is a summation of the monetary values represented in the job.

Fixed grading is usually associated with civil service systems.

Outside professional consultants are recommended for the development of a job classification and salary administration program.

Employee performance rating may be done by subjective evaluation of over-all performance or may be more formalized with the use of a check list of points to be rated and a scoring system. The dangers to be guarded against in employee performance rating include inconsistency of rating methods among supervisors, and a tendency on the part of supervisors to rate all employees at an average level.

The value of employee performance rating is doubtful because of difficulties inherent in the process which tend to produce stereotyped or otherwise unreliable results.

In the establishment and administration of salaries, recruitment problems must be considered. As a practical matter, the hospital must pay the salary required to obtain a needed employee, and exceptions may have to be made to the established structure.—**Sidney Lewine**, Director, Mount Sinai Hospital, Cleveland, Chairman; **Robert A. Bradburn**, Administrator, Memorial Hospital, St. Joseph, Mich; **Lad F. Grapski**, Assistant Director, The Johns Hopkins Hospital, Baltimore, Md.; **John Holmgren**, Associate Administrator, Central Office, Sisters of St. Joseph Hospitals, Wichita, Kan.; **Robert E. Toomey**, Director, Greenville (S. C.) General Hospital.

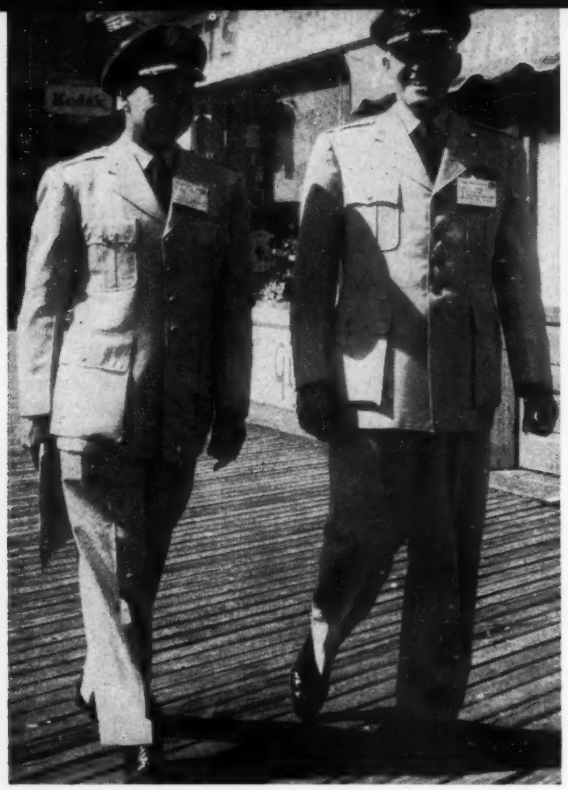
Dietitians Need More Training In Administrative Work

Management Duties Increasing In Most Dietary Departments

Heads of dietary departments are being asked increasingly to assume administrative duties. Frequently, their training has not fitted them for an administrative role.

The dietitian has both administrative and therapeutic duties. In the area of patient care, the dietitian is re-

(Continued on next page)



Above: Capt. Frank H. Lane (l.), continental division, M.A.T.S., U.S.A.F., Kelly Air Force Base, San Antonio, Tex., and Capt. James G. Moore, air training command, Randolph A.F.B., Randolph Field, Tex., hurry to an afternoon session.

AHA continued

sponsible for one of the few services in the hospital which the patient is competent to judge for himself.

Because the majority of demands upon the dietitian today are administrative, there is a great need for better training in management for dietitians. In addition, the administrator in the individual hospital should delineate the responsibilities of the dietary department head. He should also take the time to understand the problems of the dietitian and work out a solution, particularly when the dietitian lacks adequate management training.—**John J. Boardman, Jr.**, Associate Administrator, Lake County Memorial Hospital, Painesville, O.; **Berger E. Foss**, Executive Director, The Newington Home and Hospital for Crippled Children, Newington, Conn.; **Jane Hartman**, Food Service Specialist, Project for Improved Personnel and Dietary Administration, Connecticut Hospital Association, New Haven, Conn.; **Robert F. Wilson**, Food Production Manager, The Johns Hopkins Hospital, Baltimore.

Above: Mrs. Sophie Zimmermann, Chicago, AHA film review board, and Edward M. Friedlander, director, public relations, Pratt Diagnostic Clinic-New England Center Hospital, look at folder on new film, "For the Love of Life," following its premiere on opening day of convention. Film can be rented or purchased from AHA headquarters in Chicago.

Use of Outside Consultant Advantageous To Program

Consultants Being Considered Should Visit Hospital, Evaluate Problems

The necessary ingredients of a successful management improvement program are:

—Establishment of a favorable climate in the hospital for the introduction of the program.

—Fixed responsibility for coordination of the program.

—Continuity and follow-up after the program is in operation.

—Criteria and methods for evaluating results.

The need for the services of outside consultants is largely eliminated if a hospital has on its staff an industrial engineer or methods analyst whose functions have become understood and accepted by the employees. For hospitals not so fortunately staffed, some assistance in establishing a methods improvement program is available from regional and state hospital associations, and, in certain localities, from other agencies. For example, the Hospital Fund of Greater New York is carrying out a project designed to assist a group of hospitals in the New York area in developing internal methods improvement programs.

Right: Sister Miriam Vincent (l.) and Sister M. Eveline, both assistant administrators, St. Vincent's Hospital, New York City, step out in the bad weather to sniff the sea breeze.

In most cases the use of an outside consultant is advantageous. The professionally qualified consultant can bring to the project a knowledge of industrial engineering and methods analysis technics not otherwise available to the administrator. Outside consultants should be considered a tool and resource of effective management, and their employment is in no way a reflection on the administration.

Most of the bad experiences with the use of outside consultants can be attributed to a failure to provide two of the necessary ingredients for success: a climate of acceptance, and continuity and follow-up.

It is important that the consultants under consideration visit the hospital and evaluate the problems involved in establishing the program. The hospital should expect a written proposal setting forth the work to be done and

Right: A group of nurses from Holy Family Hospital, Brooklyn, N. Y., pass the colorful garden of the Dennis Hotel, Atlantic City, on their way to the convention hall for meetings.

Left: Charles J. Hackett, controller, Hackensack (N. J.) Hospital, chats with Tom McDonough (r.), Savings Bond Division, United States treasury.

providing specifically for employee orientation and for follow-up services to continue after the program is established.—**Clifford F. Schwarberg, Jr.**, Administrator, Presbyterian Intercommunity Hospital, Whittier, Calif.; **Earl J. Frederick**, Senior Associate, Cresap, McCormick and Paget, New York City; **Carl T. Heinze**, Assistant Administrator, University of Illinois Research and Educational Hospital, Chicago; **Harold E. Smalley, Ph.D.**, Assistant for Management Engineering to the Vice-Chancellor, University of Pittsburgh, Pittsburgh, Pa.; **Marion J. Wright**, Director, Jennings Memorial Hospital, Detroit.

PR Value of Nourishments Should Be Balanced Against Cost

Employees Prefer Paid Cafeterias To Food as 'Fringe Benefit'

Nutritionally, nourishments are no longer necessary, except as parts of modified diets. However, they have considerable public relations value, and their cost should be balanced against this factor. In some hospitals, "nourishments" are maintained for patients on modified diets, but "refreshments" are put on a patient request basis. Thus, food is not wasted on patients who don't want it.

Some sort of night food service is almost necessary to maintain good employee relations. The problem is finding some way to provide night food service at a reasonable cost. Food vendors have helped solve this problem in some hospitals and in others, such vendors are supplemented with a hot meal served before midnight. Early-morning snack periods are not economical but serve the purpose of raising employee morale and increasing work capacity.

Employees appear to prefer paid cafeterias to food as a "fringe benefit," and hospital administrators are generally agreed that paid cafeterias are preferable. Some hospitals subsidize paid cafeterias, and others try to recover the cost. This type of food service to employees

(Continued on next page)

Mr. and Mrs. William T. Lees, Jr., and Mr. and Mrs. Casey Greene stroll past a salt water taffy store on their way to the convention hall. Mr. Lee is administrator, Cooley-Dickinson Hospital, Northampton, Mass.; Mr. Greene is with Institutional Products Corp.

costs less because less food is wasted, and it allows better control of personnel time and of food.—**George E. Cartmill,** Director, Harper Hospital, Detroit; **Charles Davidson,** Director, General Hospital, St. Luke's Hospital, New York; **Elizabeth Finnigan,** Director of Nursing, Wayne County General Hospital, Eloise, Mich.; **Doris Johnson,** Director, Department of Dietetics, Grace-New Haven Community Hospital, New Haven, Conn.

High Processing Costs Hinder Small Hospital Laundries

Future Management Must Develop More Efficient Equipment Use

In deciding whether or not to establish a laundry, small hospitals must balance the factors of cost and organization against the type and quality of service available from a commercial laundry. Trends in costs must be determined to provide the most economical processing service. At present costs are increasing, and five to six cents a pound is the average total cost. While better and more standardized machinery and technics will decrease costs, other factors must be considered.

Criteria for deciding whether a commercial laundry can process linen more economically than a small hospital include the following:

—What services would the hospital continue to handle? If uniforms will still be processed by the hospital, for example, labor and equipment will be required.

—Are the laundry facilities the hospital has in efficient working order? Can the services of these facilities be expanded?

—How much labor will be dropped from the hospital payroll if a commercial laundry is used?

In New York City, present plans call for consolidation, in nine laundries, of the linen processing for 20 hospitals. The plan is designed to increase efficiency and reduce costs by providing lower operating costs through an increased volume of services. At the same time, the linen remains within the hospital group.

A high standard of laundry processing is of psychological value in the care of the patient. Better supervision and more attention to standards can be given when processing is done within the hospital.

Although labor costs are high in the hospital laundry, running to almost 90 percent, small hospitals can use domestic wash appliances for smaller articles and send larger linen to a commercial laundry for processing.

The laundry manager of the future must be trained for both administrative and technical roles. He must be able to develop the most efficient use of equipment and technics as well as handle personnel.—**M. Bill Newman,** Assistant Administrator, Community Hospital, Indianapolis; **Robert E. Adams,** Administrator, Research Hospital, Kansas City, Mo.; **Robert J. Dobson,** Chief, Division of Laundries, Department of Hospitals, The City of New York; **R. J. Weinzettel,** Administrator, Memorial Hospital, Waycross, Ga.; **Heywood M. Wiley,** Chairman, Educational Bureau, National Association of Institutional Laundry Managers, Philadelphia.

First Accounting and Statistical Institute Held

Workshop sessions on hospital accounting problems drew 68 administrators, bookkeepers, and divisional fiscal officers to the first annual Accounting and Statistical Institute of the central territory, Salvation Army Homes and Hospitals, held in Chicago, October 9-11. Twelve homes and hospitals and nine states were represented at the Institute, held under the direction of the group's consultant, David H. Tarlow, C.P.A., New York City.

Speakers at the opening workshop (shown standing [l. to r.] at rear of picture above) were: Brig. Douglas E. Norris, field secretary, Chicago; Maj. Karin Lindberg, director, home and hospital program, Chicago; Col. Glenn Ryan, chief secretary, Chicago; John M. Stagl, assistant director, Passavant Memorial Hospital, Chicago; Maj. Grace Green, territorial auditor, Chicago; Donald Bloom, controller, Chicago Wesley Memorial Hospital; Mr. Tarlow; and Elton TeKolste, accounting specialist, AHA.

Topics discussed included: "Value of and Need for Uniform Accounting and Statistics," Mr. TeKolste; "Hospital Financial Reports," Mr. Bloom; and "Relationship of the Hospital Bookkeeper to the Administrator and Other Department Heads," Mr. Stagl.

One session was devoted to the development of hospital books of account and related statistics.

CLIP 'N CURL SALON

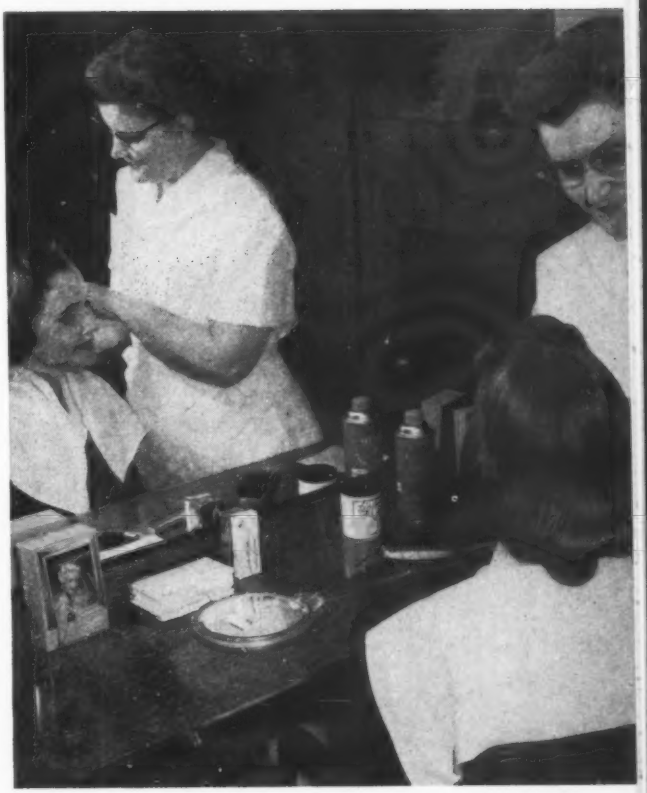
THE Clip 'N Curl Salon, recently opened at the Cook County School of Nursing, Chicago, is no ordinary beauty shop. Besides being a beauty booster for residents of the nurses' home and members of the professional staff employed by the school, the shop is building a fund to provide nursing scholarships for future students. All income left after expenses have been met goes into the fund.

The beauty parlor, staffed by professional operators, opened last summer, with the help of the 40-member Woman's Associate Board, Cook County School of Nursing. The shop's management, bookkeeping, purchasing of supplies and scheduling of appointments is entirely in the hands of the board members, who serve as volunteers, according to Mrs. Edward Dorr, chairman of the salon committee.

The Clip 'N Curl is answering a long felt need. Since there is no other beauty shop in the neighborhood, nurses can come in during their free time, in casual or play clothes. They can relax. They need not waste valuable leisure hours trying to find a shop outside the area that can accommodate them.

Clip 'N Curl gives hair cuts, sets, permanents, manicures, and tints. It employs one Negro and one white operator. The shop is open six days a week, from 9 a.m. until 8:30 p.m. Coral and black themes have been carried out in the decor. Large fans and soft FM music help everyone relax.

Customers from Illinois Research, Presbyterian, and VA West Side hospitals are also welcomed.

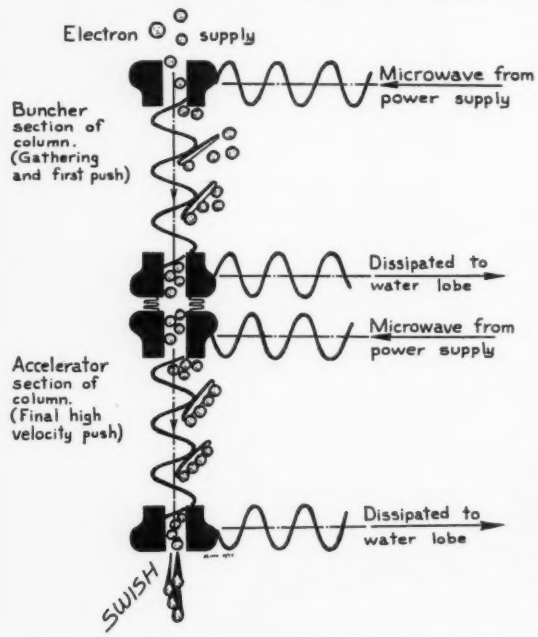


Above: At Clip 'N Curl Salon student nurse combines relaxation with hair set during off-duty hours, without having to leave hospital area.

Below: Tea celebrates the opening of Clip 'N Curl Salon at Cook County Hospital. Gloria Hansen, Barbara Mason, Karen Bechtol, Nancy Pruess, Mary Olkawski, Ruby Harris, Barbara Parsons, Jane Cryor, Joan Kantz, Marilyn Walters, Linda Shorey and Maryann Meydrich, all student nurses, stop for a bite to eat. Mrs. Thomas R. Coyne, board member, assists at the punch bowl.

Diagrammatic View Of Accelerator

7 MEV Microwave Linear Accelerator


Electron supply
Microwave from power supply
Buncher section of column. (Gathering and first push)
Dissipated to water lobe
Microwave from power supply
Accelerator section of column. (Final high velocity push)
Dissipated to water lobe
SWISH

Above: Electrons, as shown graphically here, literally "hitch a ride" on the radio waves generated by the accelerator. They gather speed as they journey downward in the vacuum tube, and by the time they reach the sterilizing room, they are traveling at about 97 percent the speed of light. There, magnetic coils sweep them from side to side at about 200 or 300 cycles per second. They come out through a long, narrow slot in the bottom of the machine —the electron beam scanner. The scanner distributes the deeply penetrating electrons evenly through the product being sterilized, resulting in thorough sterilization.

This reverse print serves to point up the fact that one of man's most recent scientific achievements has now been harnessed to serve every-day hospital needs. See positive photograph on page 24 for identification of persons.

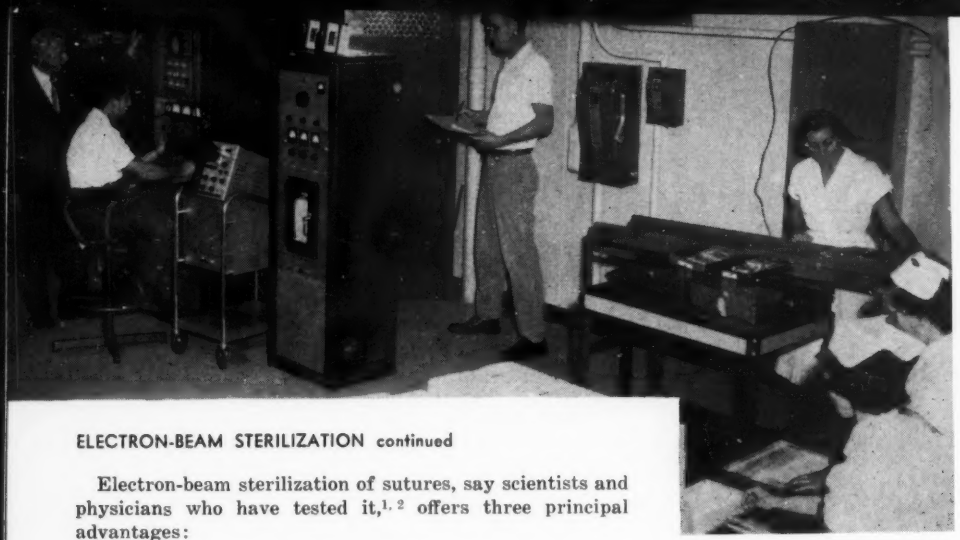
Now the Electron Beam Goes to Work Around the Clock!

Opens a New Era in Product Preparation

THE first sutures sterilized by electron-beam radiation will be marketed early next year, by Ethicon, Inc.

The company has installed a 7,000,000-volt linear accelerator in its plant at Somerville, N. J. Its completion marks the culmination of 10 years of research by teams of scientists, physicians, and technicians of Ethicon and the High Voltage Engineering Corp., Cambridge, Mass., which developed the first commercial Van de Graaff and linear accelerators for electron-beam sterilization.

Although several other companies in the medical field have been using this type of sterilization on a limited basis for some of their products, Ethicon has the first compact, in-plant installation of such equipment. A newly designed microwave linear accelerator, it occupies a much smaller area than the original Van de Graaff equipment, enabling ease of inspection, maintenance, and operation. *(Continued on next page.)*



Shown here is a view from the opposite side of the room pictured on the preceding pages. Walton Van Winkle, M.D. (l.), director of research, stops to check master control board with Bernard Indeck (seated), electron-beam manager. Albert Hansen, electron-beam technician, is in center (in preceding picture he appears on balcony above, at cabinets housing power supply). Mary Sica (facing camera) checks trays of sterile sutures as they come off conveyor belt, while Rose Dalessio and Judy Varga assemble unsterile supplies on trays. Note portable Geiger counters on top of cabinet in center.

ELECTRON-BEAM STERILIZATION continued

Electron-beam sterilization of sutures, say scientists and physicians who have tested it,[1,2] offers three principal advantages:

1. An increase of 10 percent or more in the tensile strength of the surgical gut, which may allow the surgeon to get the strength he needs from a smaller size suture. At the same time, there is an increase in the pliability of the sutures.

2. Sterilization of the sutures in their final sealed containers, which eliminates the possibility of recontamination during manufacturing.

Under the present method, the final step in assembly—closing of the tube—is performed *after* the sutures have been sterilized, making it necessary for personnel responsible for this operation to observe the same strict aseptic technic used in an operating room. The women scrub, as nurses do for surgery, and are gowned and gloved when they handle the open-ended tubes.

3. A substantial increase in the safety margin for sterilization. Irradiation doses applied to the material exceed by 50 percent the lethal dose for the most resistant microorganisms studied, including bacterial spores.

On the Ethicon assembly line for sterilization by Linac (for "linear accelerator"), asbestos-lined trays, filled with sutures in presealed containers, will move on a conveyor belt from the ground floor of the building into the lower room in which sterilization takes place. Each 9" x 15" tray holds several dozen sutures, which are sterilized as they pass under the beam. The dosage is more than 3,000,000 reps (roentgen-equivalent-physical units)—approximately 50 percent more than is necessary to kill the most resistant spores.

While the belt is carrying its load to and from the "target room," the electron-beam manager, at the master control board on the floor above, can tell immediately, by checking his monitor dials and meters, what conditions exist in the room below. These instruments inform him—visually and by sound—if there is a variation of more than five percent in the speed of the production belt, the scan of the beam, or the electron dosage. In addition, installation of a television monitoring system is being considered, so that personnel may actually see what is going on below.

A gasoline-powered auxiliary generator has been installed which would take over automatically in case of a utility power failure. Thus, the vacuum would be maintained in the accelerator tube which contains the electron beam and production of fully sterilized sutures would continue.

X-rays are a by-product of the electron-beam sterilization process. The concrete walls in the sterilization room are seven feet thick, to keep these rays from escaping into occupied areas outside. When the machine is in operation, of course, no person is allowed to enter this room, but when the accelerator is turned off, it is quite safe to enter.

The product sterilized by this method is *not* made radioactive, emphasizes Walton Van Winkle, Jr., M.D., Ethicon's director of research.

Despite removal of the "human element" in packaging sterile sutures, sterility will still be as carefully checked as ever. Every "batch" of sutures is held in quarantine until extensive microbiological tests prove their sterility. Only then are they released for distribution. This system will be maintained. In addition, a new testing

method, which involves the use of polyvinyl chloride film, has been developed and patented by Ethicon. A piece of the film is placed on each tray of sutures. The electron beam turns the film green. Later, the film is baked, and is compared with a chart line which has been worked out to determine, from the shade of color, how much dosage has been given the batch.

Patent rights to the safety check method have been placed in the public domain so that the discovery may be of universal benefit.

REFERENCES

1. Narat, Joseph K.; Cangelosi, Joseph P.; and Belmonte, John V.: Electron Sterilization of Catgut, *Surgery*, 41:324-27 (Feb.) 1957.
2. Fitzgerald, William J.; Foley, Hugh; and McDowell, David: Clinical Evaluation of Electronically Irradiated Catgut, Number 2-0 Chromic and Number 3-0 Plain, in Episiotomy Repair, *New York State Journal of Medicine*, 57:2231-32 (July 1) 1957.

What's Ahead for This Process?

● What are possible future applications of electron-beam sterilization in hospitals and hospital industries?

The method's potential in industries is great, F. E. Foster, former sales manager, High Voltage Engineering Corp., told the annual convention of the Association of Operating Room Nurses in Boston in 1956. Eighty percent or more of all standard drug preparations can be sterilized satisfactorily with electrons, without any damage or excess loss of potency, Mr. Foster said.

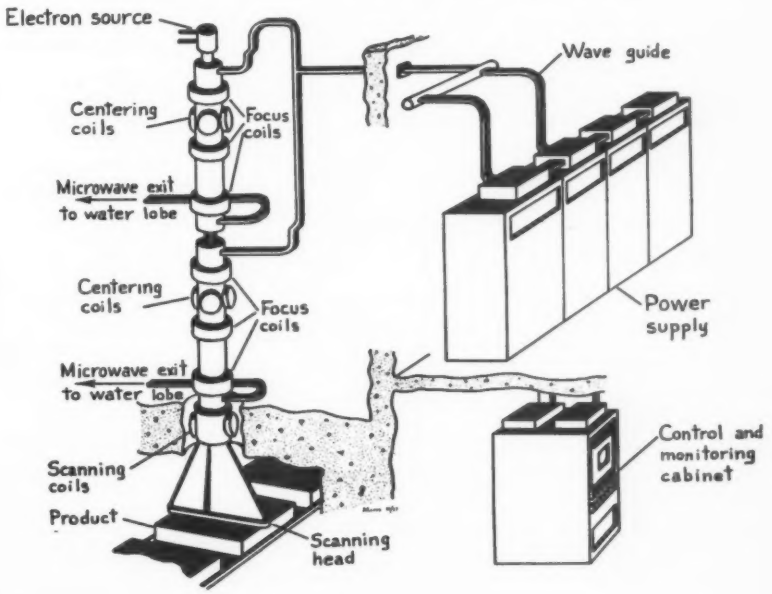
In addition to sutures and pharmaceuticals, other likely materials for electron-beam sterilization, according to Mr. Foster, are surgeons' gloves (perhaps pre-packaged in polyvinyl), surgeons' blades, polyvinyl chloride objects used in surgery (drainage tubes, for instance), and catheters. Polyethylene bulk packaging bags for antibiotics are now being processed.

In hospitals, radiation sterilization probably will never replace autoclave sterilization. Nor will it be practical for many hospitals to have their own units, because the expense involved in an installation is great. However, the cost of electron radiation sources is constantly being reduced. High Voltage has announced a new 1½-million-volt Van de Graaff accelerator at a lower total cost and with more total radiation power output than heretofore available.

If a product can be sterilized satisfactorily by heat, without any damage to the product or the package, there seems to be little need for considering radiation. But if heat is unsatisfactory—as it is for sterilizing human tissues such as bone grafts, aortas, and autopsy material, for example—radiation should be explored since it has proved successful for such sterilization.

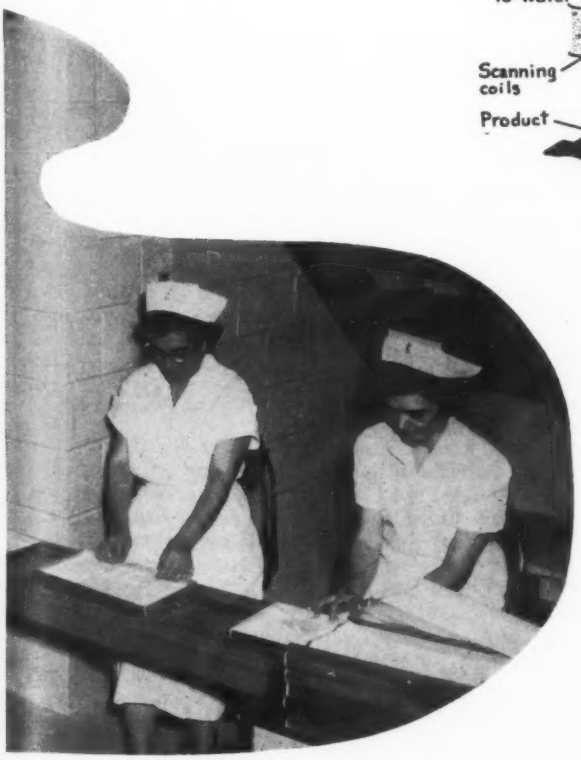
SCHEMATIC VIEW OF ACCELERATOR COLUMN

7 MEV MICROWAVE LINEAR ACCELERATOR



"MEV" means "million electron volts"—for practical purposes, a million volts. An electron, accelerated by a million volts, acquires a million electron volts of energy.

Below: Dr. Van Winkle examines sutures as Mary Sica takes them off trays coming out of sterilization room. Rose Dalessio and Judy Varga put sealed suture tubes on asbestos-lined trays on conveyor belt which will carry them down into sterilizing room.



How to Confine, Extinguish Fires, Carry Out Evacuation if Needed

Second in a series

By Ed Meyer and Joe Corbett*

The total fire-safety program for Los Angeles hospitals, according to Benjamin F. Renfro, fire prevention engineer, education section, Los Angeles Fire Department, is built around four factors which cause major fire losses: structural deficiency of buildings, delayed discovery of fires, flammable contents of buildings, and the human element. This is the second of three articles on the fourth factor—the human element.

In the first article, which appeared in the October issue, the authors described the educational and training aids prepared before a fire-safety program is put into effect in a hospital. They outlined the following five steps in a fire-safety program:

I. An internal fire prevention program.

II. Safety to life.

III. Notification of the Fire Department.

IV. Confining and attempting to extinguish the fire.

V. Evacuation if necessary.

They then discussed steps II and III. This installment of the series covers steps IV and V, and the concluding article, in the December issue, will deal with step I.

IV. Confining and Attempting to Extinguish Fire

• Before one can confine or attempt to extinguish any fire, it is necessary to understand what fire is. One must know what different things make up a fire, and then how this knowledge can be of assistance in attempting extinguishment.

The usual definition of fire is combustion at a rate great enough to cause heat and light. Combustion has three requisites—FUEL, HEAT, OXYGEN. In the fire services, we call this the fire triangle.

One leg of the triangle is fuel. Fuel is anything that will burn, such as cloth, paper, wood, fiber, liquids, gases, and vapors. In all of these fuels, however, ONLY THE VAPORS BURN. The fuel, if not already in vapor form, must be converted to vapors (usually through heating to a point at which vapors are given off).

The second leg of the fire triangle is heat. Heat must raise the fuel to its ignition temperature. This rise usually occurs when vapors are being given off rapidly enough to support and propagate the flame. From then on, the burning vapors continue to raise the temperature of the surrounding materials to a point at which more vapors are given off.

Once this cycle is started, fire grows and spreads so rapidly that it is unbelievable. This is why we put so much emphasis on immediate action. If the fire can be discovered when it is still in its incipiency, it can be easily extinguished. Give a fire five minutes, however, and it can spread to gigantic proportions. In fact, there is a saying in the fire services that the first five minutes of a fire are more important than the next five hours. There has never been a truer statement.

The third leg of the triangle is oxygen. Oxygen mixes with the fuel and supports combustion, but OXYGEN DOES NOT BURN.

If we remove any one of the three legs of this fire triangle—fuel, heat, or oxygen—a fire cannot exist. This will be discussed more thoroughly later.

Heat can be transmitted in three ways: radiation, conduction, and convection. Radiation is the transference of heat waves in straight lines through space—for example, sun rays and rays from gas or electric heaters. Fire has been known to spread by radiation from building to building (not adjoining one another) at distances in excess of 100 feet.

Conduction is the transference of heat in, on, or through a conducting material. For example, one end of a metal rod will become heated when the other end is placed in a heat source. The heat travels through the rod. Metal beams and pipes can conduct heat, sometimes causing ignition of combustible material in contact with them.

Convection is the transference of heat by currents—for example, rising and traveling smoke, gas, or vapors. It is a known fact that hot air rises. Smoke is hot air filled with products of incomplete combustion and poisonous gases such as carbon monoxide, methane, and hydrocyanic acid gas. Heated fire gases are much more deadly than any war gas. One good breath of superheated fire gas is usually fatal.

Knowing these few facts about fire, one can attempt to confine and extinguish it.

To confine the fire to as small an area as possible is of utmost importance. This can be accomplished by keeping all doors closed (an ordinary wooden door, when it is closed, offers considerable resistance to the spread of fire); by closing transoms (these should be eliminated); by closing fire doors (if they have not operated automatically), and by making sure all vertical shafts are closed (such as stairwells, elevator shafts, dumbwaiters, laundry chutes, and rubbish chutes).

Never take any burning material into a corridor, where the fire has an opportunity to spread both horizontally and vertically. Never take a burning bed out of the

*Inspectors, plant protection unit, Los Angeles Fire Department.

room. Remove the patient, not the bed, and then SHUT THE DOOR!

After everything possible has been done to confine the fire, an attempt can be made to extinguish it. It is necessary first, however, to know what class of fire it is in order to know what extinguishing agent to use. Fire is divided into three classes, A, B, and C, and so are the extinguishing agents.

A Class A fire is one in ordinary combustible materials, such as wood, paper, cloth, cotton, and fibers, in which extinguishment is accomplished by cooling the burning material to a point below its ignition temperature. Since the most common and, generally speaking, the best all-around cooling agent is water, water-type extinguishers become Class A extinguishers, and are the proper ones to use on Class A fires. Some examples of Class A extinguishers are the soda-acid, the water tank charged with gas cartridges (carbon dioxide, nitrogen, or air is used in these), the water pump tank, and hose lines.

EXTINGUISH BY SMOTHERING

A Class B fire is one involving flammable liquids, such as gasoline, oil, alcohol, benzine, ether, and naphtha, in which extinguishment is best accomplished by smothering (excluding the air from around the burning material). A wide variety of dense, heavier-than-air gases, powdered chemicals, and foam-producing substances are used in Class B extinguishers. Some examples of these extinguishers are carbon dioxide (CO_2), dry chemical with a gas cartridge, and foam. Water, except in a fine spray or fog, does not extinguish Class B fires. Since water is heavier than most flammable liquids, it sinks to the bottom of the container, thereby causing the container to overflow and compound the problem by spreading the fire.

A Class C fire is one involving electrical equipment, appliances, and wiring. In such a fire, the use of non-conductive extinguishing agents will help prevent injury to the operator through electric shock. The dry chemical unit with a gas propellant cartridge and the carbon dioxide (CO_2) inert gas type are examples of Class C extinguishers.

In Los Angeles we definitely discourage the use of carbon tetrachloride (also known as tetrachloromethane, perchloromethane, and CC14) extinguishers. Carbon tetrachloride is a pleasant, sweet-smelling liquid that is clear and colorless at normal temperatures. It is an excellent fire extinguisher, but it turns to vapor easily at room temperatures. This vapor is more than five times as heavy as air, and settles quickly to floor levels, lower floors, and basements. At high temperatures, it decomposes and forms very strong poisons, one of which is phosgene. Breathing even a little phosgene, a deadly war gas, may be fatal.

Injury can result from breathing the vapor of carbon tetrachloride, swallowing the liquid, or letting it contact the skin or eyes. It is easily absorbed through the lungs and mucous membranes, and to a lesser extent through the skin. One exposure to it may harm or even kill a person, if the concentration is high. Lower concentrations may also be harmful if one is exposed to them repeatedly, since the harmful effect is cumulative.

Most injuries result from breathing the vapors, which can cause severe and even fatal cases of liver or kidney damage. It seems illogical for a person to use carbon tetrachloride in attempting to extinguish a fire when its use might kill him.

Once one is familiar with the different classes of fire and the proper fire extinguisher to use, it is of utmost importance to be able to recognize the different types of extinguishers immediately and to know the location of all extinguishers in his working area, in addition to knowing how to operate each one.

In our training program, we devote about two hours to this subject. The first hour is spent explaining the operation and use of extinguishers. A film, *Know Your Fire Extinguisher*, is also shown. The next hour is spent in actual outside demonstrations during which various types of fires are built and different types of extinguishers are used to extinguish them. Fires are extinguished first by the instructor, and then by each person in the class. Only through such practical experience will people become familiar enough with and have confidence in their fire extinguishers. Confidence is very important if it ever becomes necessary for an employee to use a fire extinguisher.

The use of interior wet standpipe hose lines is also important. Special instruction on their proper use and the different ways they can be put into operation will eliminate any hesitancy in using them. Putting a hose line into operation calls for teamwork, which is the whole basis of this program. In all these fire-safety operations, as with anything else, the more practice one receives, the more proficient he becomes.

V. Evacuation

In dealing with fires in occupancies which have a high life hazard, such as hospitals, no program will be effective unless the employees are very familiar with the various ways to get people out of the fire danger area—how these methods are interrelated and how best to accomplish each one. There are four types of evacuation:

Partial evacuation amounts to removing one or more persons from a dangerous or potentially dangerous room or ward. After the necessary removals are made, an attempt must be made to extinguish the fire with first-aid fire-fighting appliances (fire extinguishers and/or hose lines). If this is not possible, the door must be closed and the threshold sealed with a wet towel or blanket. If the fire continues to grow so that an entire area is in danger, the next step is to proceed with either horizontal or vertical evacuation.

Horizontal evacuation consists of moving all patients laterally to the nearest safe area. Patients in immediate danger should be moved first. Those who might be separated from safety if the fire enters the corridor should be included in the first moves. Panic is never caused by helpless people. Therefore, next move the ambulatory patients. They should hold hands and be led to a safe area. All rooms should be checked for patients, and all *windows and doors closed.*

Recheck the patients once they are in the safe area. If there are corridor cut-offs, seal the threshold. Be alert for any further movement.

Vertical evacuation is downward movement to a safe area. If the stairwells and shafts are enclosed, safety may be found one floor below the fire. If time permits, however, moving patients two floors will provide a greater margin of safety. Some of the carries or removals are particularly good for this purpose. Safe elevators not in immediate fire danger can be used to move patients in carts, wheel chairs, stretchers, and blankets.

(Continued on next page)

If there are open stairwells, shafts, and chutes throughout the institution, it may be necessary to consider vertical evacuation of all floors. This may require moving horizontally to a stairwell temporarily remote from the smoke and fire, or traveling to the most remote fire escapes. In structures of this type, the most dangerous area (excepting the fire floor), is the top floor. Smoke and heated gases rise. In a fire, smoke—a product of incomplete combustion containing many types of poisonous gases—has been known to reach temperatures of 1500° F. or more. It is not difficult to understand, therefore, why so many of the people who die in fires, die of asphyxiation in locations far from the actual fire.

4. Total evacuation means vacating all floors and moving all patients to a place of safety, which might be the basement or an area outside the building. It will be necessary to use all safe stairways, elevators, and fire escapes. The help of everyone available will be required. This action must be taken floor by floor—with enough properly trained help above and below to keep traffic moving quickly and in an orderly fashion. A command and dispatch center should be set up at a switchboard and in the lobby.

In contemplating evacuation of any kind, particularly vertical or total, personnel should be trained to perform certain duties as teams. Then, in case of disaster, these competent people will perform almost automatically. There should be *loading teams* to provide patients with carts, wheel chairs, stretchers, and blankets. There should be *moving teams* to get these conveyances to the elevators and stairways in the fire area. *Moving teams* are also needed below the fire to move these conveyances away from the elevators and stairways.

There should be *carrying teams* to get the patients down stairways and fire escapes. With this system it is possible to have an orderly withdrawal from the premises. Without a preconceived plan in any emergency situation, a disaster is almost inevitable.

The key to the whole program is training. The only way this can be accomplished is for management to be completely aware of the danger. Management must give its full support and cooperation to the local fire department in order to gain a program such as this one. The fire department will conduct the necessary training sessions. These sessions, in order to be effective, must include every employee of the hospital. Training groups should be small enough to reach every person.

After every employee has had the complete training and an opportunity to study a copy of the entire plan, it is absolutely necessary that several fire drills be conducted on each shift. At least one full-scale fire drill for each shift each month should be part of the fire-safety program. There should be enough fire department members and members of the hospital management staff present (stationed throughout the hospital) to pick out any flaws or weak spots in the program. Only in this way will it be possible to tell how effectively the program will work should an emergency really develop.

Any flaws or weak spots found should be corrected. Changes found necessary should be incorporated immediately in each booklet. Everyone must be made aware of the changes.

Patients must be made to understand that a fire safety program is another of the many services rendered by the hospital for the welfare of the patient.

Next month: An internal fire prevention program.

One department's role in a hospital fire-evacuation program

Evacuation Program for X-Ray Department

By Sister Thomas Aquinas, C.S.J.*

● In November, 1953, our laboratory had a fire caused by fumes of acetone being ignited by the pilot light of a gas refrigerator. Fortunately, through the quick action of the medical technologist on duty and several doctors, the fire was well under control in a few minutes, and no one was seriously injured.

A safety program was already in progress at this time and safety equipment and fire doors had been installed. The fire caused speeding up of the formation of the present rules and regulations for safety and evacuation. A manual was prepared giving general and specific instructions to carry out a fire prevention and evacuation program.

The first thing to be done was the installation of an automatic fire alarm system by a reliable alarm company. There are several types of alarms in use. One, known as the breaker station, is a small metal box in which a piece of glass is broken, thereby notifying the fire department directly, the switchboard, and the nurses' home by means of a bell. This type of alarm is installed on all floors on which personnel are on 24-hour duty.

The second type, the fixed-temperature alarm, is a small metal cup-shaped piece of apparatus which is used in kitchens and places in which there is a large amount of steam. It is placed in the ceiling and set at 195°, so that when the temperature reaches this mark, the fire department, the switchboard, and the nurses' home are automatically notified.

The third type, also metal and cup-shaped and placed in the ceiling, is known as the rate-of-rise type. It is placed in all areas in which personnel are not on 24-hour duty, such as the x-ray department, laboratory, surgery, storage rooms, cafeteria, and pharmacy. This type sets

(Continued on page 31)

*St. Joseph's Hospital, Kansas City, Mo. This article is adapted from a paper presented at the Conference on X-Ray Technology, during the annual convention of the Catholic Hospital Association, Cleveland, May, 1957.

Third in a series on public relations and fund-raising

Planning a Capital-Fund Campaign for Your Hospital

By A. C. Barnett*

In two articles on a subject of increasing concern to officials of America's voluntary hospitals, the author adopts the question-and-answer technic to (1) present the steps which can be of significant aid in determining the justifiable need for an expansion program and (2) appraise the success potential of a campaign and develop a soundly-conceived plan to meet the need.

PART I

Q. How great is the present need for hospital construction?

A. Despite the upswing in new construction, during which $2.9 billion has been expended in the last 10 years to create new nongovernmental hospital facilities, the shortage in hospital beds is still acute. It is estimated that more than 800,000 additional beds are required to meet the needs of an ever more health-conscious public.

Moreover, if we are to keep pace with the population increase, entirely aside from reducing the present bed shortage, an additional 81,000 beds will be needed in the next decade. And the growing use of hospital facilities resulting from improved social and economic conditions will call for yet another 121,000 beds.

These significant figures are cause for considerable concern to the 50,000 or more men and women who, as trustees or directors of America's nonprofit hospitals, give time and energy, without pay, to improve community health. These figures, and what they indicate, emphasize facts known all too well by the loyal, hard-working, medical, administrative, and nursing staffs of our hospitals.

Q. What is being done to meet the need for additional hospital facilities?

A. Current estimates show that private hospital construction may reach a record $423 million in 1957, exceeding by several million the largest previous expenditure, made in 1951.

On the basis of experience, approximately one-half of the $423 million may be expected from private contributions and funds, including corporate gifts, subscriptions by medical staffs, individual contributions, foundation grants, bequests, and other sources. Well-planned capital-fund campaigns will be the means whereby much of this money will actually be obtained.

Q. What is the first step a hospital should take toward meeting its particular need?

A. Obvious as it may seem, the first step by a hospital's board in planning to meet what it believes to be a need for expansion and modernization should be to determine its case *in complete detail.* Gone are the days, if indeed they ever existed, when some hit-or-miss plan of expansion could be sold to the public.

Essential, of course, are facts and figures regarding overcrowding, lack of adequate facilities, and such other data as will point up the need. Equally necessary are plans which will show how the need can be met most effectively and economically, cost estimates, and an appraisal of the situation in regard to the timing and organization of a campaign that may attain what can be shown to be a realistic financial objective.

Q. From whom can a hospital's trustees obtain advice regarding a proposed program of expansion and modernization?

A. There are four sources from which a hospital's governing board can obtain information and advice of inestimable value, which may save the board much time and money. These sources include:

1. The hospital's own medical and administrative staffs
2. A recognized hospital consultant
3. An architect who is familiar with hospital design
4. A firm of professional fund-raising counsel with substantial experience in the hospital field.

Q. Why consult the staffs?

A. The medical and administrative staffs should be the first from whom opinions are sought. This recommendation seems rather elementary and obvious, yet campaigns have been launched in which a hospital's doctors learned what new facilities were planned only when they read the brochure.

(Continued on next page)

*Mr. Barnett is executive vice-president, Tamblyn and Brown, Inc., New York City, professional fund-raising and public-relations counsel to hospitals and other nonprofit institutions, and a charter member of the American Association of Fund-Raising Counsel. He also is a member of the board of directors of South Nassau Communities Hospital, Oceanside, L. I., N. Y.

From their daily visits to the hospital and their thorough understanding of its shortcomings — and every hospital has them—the medical staff members can, and will, make many helpful suggestions toward establishing the case. Moreover, their interest in the forthcoming campaign, their personal gifts, and the degree to which they will seek the support of their patients depend on their being on the "inside," so to speak, when plans are being made.

Q. How can a hospital consultant aid in the preliminary planning for a campaign?

A. Because of his extensive and up-to-the-minute knowledge of approved hospital technics and practices, a hospital consultant can take a thoroughly objective viewpoint in considering the problems of an individual hospital. The larger the hospital and the more complex its organization and services, the greater can be the consultant's contribution.

He can determine not only the immediate health needs of the particular community, in terms of hospital facilities, but also the long-range requirements.

As a result, the qualified consultant can plot the course which the hospital should take, both now and in the years ahead, to keep abreast of its public's demand for treatment and care. Because his suggestions concerning the specific design of the hospital's proposed addition can lead to more economical operation of the plant, this factor will be of significant value in selling a capital-fund program to the public.

His advice will cover many angles, will include information on the probability of government grants, and will do much to clarify the thinking of the hospital's board and staff members. Subsequently, his quoted opinions and advice will do much to substantiate the case and recommend it to the public.

Q. What is the architect's role in relation to the proposed campaign?

A. Once the hospital's trustees and their advisers have determined the type and amount of new construction and/or reconstruction which is needed, the architect can further implement the proposed program of expansion and modernization. Through preliminary sketches, he can enable the board to see how the desired results may best be accomplished. Most important is that he will provide the cost estimates, which are vitally essential.

Q. How can professional fund-raising counsel help in determining the advisability and the nature of a proposed capital-fund campaign?

A. Professional fund-raising counsel should be a member of the team which assists a hospital's governing board in arriving at its decision about undertaking a program of expansion.

Upon invitation, most firms in this highly specialized field, particularly those which are members of the American Association of Fund-Raising Counsel, will conduct a survey to establish two factors:

1. The amount which it appears reasonable to believe may be obtained in a capital-fund campaign.

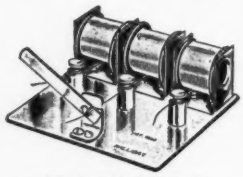
2. The type of campaign, the plan and organization likely to prove most effective under the particular circumstances.

No matter how good the case may appear to be, the results of this survey can throw a powerful light on an all-important question: Is it reasonable to suppose that the hospital really has both a provable case and a realistic goal that can successfully be presented to its constituency?

* * *

In the December issue of HOSPITAL TOPICS, Mr. Barnett will discuss the various ways in which professional counsel determines the two factors that have such great bearing on the decision to conduct a campaign, and will outline basic requirements for a successful capital-fund program.

TO SAVE OPERATING ROOM TIME and TO HELP THE SURGEON



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"We have Blue Cross."

(Continued from page 28)

off the alarm when the temperature rises 15 degrees 10 seconds. It also has a fixed temperature of 160°, so that should there be a small smouldering fire, the alarm would go off when the fixed temperature was reached. In our x-ray department each radiographic room, darkroom, and office is equipped with this type of alarm.

We have had quite a few false alarms. A small room in which mops were boiled was equipped with the rate-of-rise temperature alarm. One day, while the mops were boiling, someone opened the door, causing the steam to rise and set off the alarm. Soon we were surrounded by five companies of the fire department. On another occasion the same thing happened in surgery—the door of the sterilizer was opened, thereby setting off the alarm. We remedied the situation by installing the fixed-temperature alarm set at 195°.

A rate-of-rise alarm was placed in the clothes chute. We had two false alarms as a result. It was discovered that when clothes were put in the chute, cold air was brought in by suction, and the temperature dropped in the chute, and then rose rapidly, thus setting off the alarm, since it was set to go off when the temperature rose 15 degrees in 10 seconds. This situation was remedied by taking out the fire alarm and installing a sprinkler system which goes off automatically when the temperature reaches 160°.

When a fire is discovered on a floor and the alarm turned in by one of the above methods, the switchboard operator announces over the public address system a code which notifies all departments of the fire. The code is "Emergency Dr. Red (three times), Emergency, Dr. Red—2 East (place of fire)." The administrator, superior, and other officers, as well as all floors and departments, are notified by the switchboard. We will confine this article to the part played by the x-ray personnel in case of fire elsewhere in the building, and/or in the x-ray department.

Should the fire occur elsewhere in the building, the x-ray department closes all doors and windows and turns off the dryer, therapy machine, control panels, and dictating machines. Patients are taken from the radiographic rooms and put in wheel chairs or on carts. All patients are kept in the x-ray department until the "all clear" signal is given over the public address system—"Dr. Red—emergency ended" (three times).

EMERGENCY PROCEDURE

One or two technicians are assigned to stay with the patients in order to allay their fear; one technician is stationed at the telephone to receive any messages or instructions. All personnel not needed in the department are sent to emergency headquarters, which is the auditorium in the nurses' home. Since the elevators are needed for firemen and equipment, all personnel must walk down the stairs to the auditorium.

At the emergency headquarters are kept blankets and equipment needed. A direct telephone line is kept open between the scene of the fire and the emergency headquarters, so that personnel may be sent to the scene of the fire as needed. Should complete evacuation be ordered by the fire department, the personnel from emergency headquarters would be used for this purpose. When the "all clear" signal is given, the personnel return to their respective floors and departments.

Should the fire occur in the x-ray department, the technician who discovers the fire takes the patient from the room, closes windows and door, and turns in the alarm. The fire extinguisher is next procured and used. All personnel are quietly notified by code of the fire. Our code is "Emergency—Dr. Red—Room I, darkroom"—or wherever the fire might be. In the meantime windows and doors are being closed, equipment turned off and patients removed from the department by walking, wheel chair and cart to what is known as the "safe area"—an area on each floor beyond the fire doors. On the sixth floor, which houses the x-ray department, laboratory, delivery rooms, and surgery, the patients are moved to an opposite wing of the hospital. In our case we would move patients to either the laboratory or surgery. The hospital is in the shape of an X. A chart showing the locations of the safe areas, alarms, and fire equipment hangs in a prominent place on each floor.

TYPES OF EXTINGUISHERS

There are several types of extinguishers. One is the soda-and-acid type, which is used on ordinary fires.** The CO_2 extinguisher is used on fires caused by electricity. A third type, a foam extinguisher, is used on fires in a paint shop. These three types must be recharged every year or after use. A fourth type, a plain water-and-air extinguisher, can be replenished by merely adding water or by pumping air. The x-ray department, because of its electrical wiring, has the CO_2 type.

After our program was organized and the rules and regulations printed, monthly fire drills were held. Each month a different floor or department was chosen. A fire was discovered, an alarm turned in, and each procedure outlined above, carried out. This was done on all three shifts, to enable all employees to see what should be done.

At the present time a class is held once a month at which instructions are given on how to turn in the alarm, use the extinguishers, and evacuate patients. New employees are required to attend six classes.

It is necessary that nothing obstructive be placed in corridors which lead to exits. Because of lack of space someone decided to put the drum of barium in the corridor which led to the exit. This was immediately called to our attention by the fire department.

When light bulbs burn out in the exit light, be sure they are replaced immediately. We had an embarrassing experience in this regard. One day a patient was waiting in the dressing room for a barium enema. He remarked that the exit light was out. I replied that I had not noticed it. He informed me he was a fireman and proceeded to tell me how important it was to keep the light burning at all times. Should there be a large amount of smoke and no light available, no one would be able to find his way out of the department.

A few points to remember in the x-ray department are:

1. Keep a list of instructions in a prominent place so that all may know what to do in case of fire.

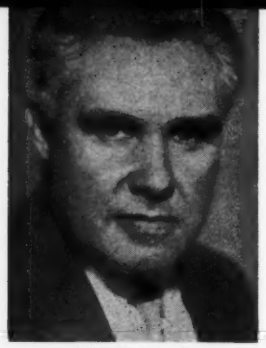
2. Assign definite personnel to certain jobs in the fire drill.

3. Learn the location of alarms and extinguishers and know how to use them.

2. Have a practice drill occasionally in order to learn how to work calmly and quietly.

5. Keep exit lights burning at all times.

**The soda-and-acid type of extinguisher should not even be available in an x-ray department, since it contains an acid electrolyte which is an excellent conductor of electricity.



John G. Steinle

Consultant's Corner

By John G. Steinle

Q. What type of floor do you recommend for a new hospital? What are floor costs?

A. The following are the types of flooring recommended by a housekeeping specialist. In making these recommendations consideration was given to:

Initial cost
Cost of maintenance
Life expectancy.

1. Kitchen and utility, areas surrounding them, bathrooms, and operating rooms—terrazzo flooring. This flooring insures easy and efficient maintenance and will require no waxing. Consideration may be given to hollow brick tile in the kitchen.

2. Basement areas other than storage and boiler rooms —asphalt tile. Darker shades are preferred for easy cleaning and maintenance.

3. Entranceway and lobby, which would be subject to heavy traffic—terrazzo floors.

4. Hospital corridors—rubber tile, for quiet walking and also easy maintenance.

5. Patients' rooms—vinyl tile. This resilient type of flooring requires the least maintenance, yet it will add beauty.

Any areas in which chemical spillages might be experienced should have either vinyl or grease-proof asphalt tiling.

It is recommended that white background or light, decorative colors not be selected in any resilient flooring, as maintenance costs for these colors are double those for medium or darker-colored floors.

Depending upon color selection and quantity used, the approximate costs of the above listed types of flooring (subject to the contractor's cost in the area) are as follows:

Terrazzo—@ $1.50 per square foot
Vinyl—@ $.50 to .75 per square foot
Rubber—@ $.35 to .55 per square foot
Asphalt tile—@ $.15 to .25 per square foot.

Q. Are there any federal loan provisions for construction of housing for interns, residents, graduate nurses, and technicians?

A. Treating the intern and resident problem separately offers a fairly simple direct application of the recent amendments to the College Housing Loan Program. (See the August issue of HOSPITAL TOPICS for full instructions on making an application.)

There is no similar direct loan program for financing housing for staff nurses and technicians. There are, however, FHA mortgage guarantee programs which might apply and which might make it easier to obtain financing on favorable terms through private channels. These are found in Sections 207 and 213 of the National Housing Act. Both sections provide guarantees for mortgage loans at 4½ percent interest for terms of approximately 40 years.

There are two major advantages of Section 213 over Section 207. First, the housing constructed may be all, or predominantly, units designed for single persons, whereas Section 207 construction must be predominantly family-type units. Second, under the provisions of Section 213, it is possible to obtain the participation of the Federal National Mortgage Association in the financing, which would considerably facilitate obtaining mortgage money through private sources.

On the other hand, the provisions of Section 213 would require that the project be incorporated separately as a consumer cooperative. This would call for careful planning to assure proper control by the hospital.

The application of either of these FHA mortgage guarantee programs would require a ruling by the FHA Commissioner.

Q. What is the trend in the use of residences for graduate nurses?

A. The use of residences by graduate nurses is dependent upon a number of factors. Some of these are:

—Location of the hospital. A hospital in an isolated area, in which apartments are not available, will have a greater need for a nurses' residence than a hospital in an urban center.

—Location of the nurses' residence in relation to the hospital. Some separation is usually preferred by nurses. Also, graduates generally do not like living in the same facility as student nurses.

—Design of the residence. The dormitory type will not be used. Even a "hotel" model residence meets with use resistance. The ideal residence has separate apartments or motel-apartment-type units.

Generally the occupancy of nurses' residences has not been high. In considering whether or not to construct such a facility, it is suggested that you look at the use of nurses' living quarters in other hospitals in the area.

Do not simply consider the current occupancy. Find out how many nurses now on the staff lived at some time in the residence. Often a nurses' residence is important as an attraction to new nurses. A nurse will live in the residence for several months until she has made friends and found a place to live, and then will move out. She might not have come to a particular hospital if there had not been a place for her to live until she became familiar with the community.

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Business Office Operations

Eleventh in a series on hospital organization, based on lectures given at meetings of the Association of Western Hospitals and allied state groups

Third-Party Payors

By John H. Gorby*

This is the third of four articles on business office operations. The first two were on accounting and the accumulation of patient charges. The final article, credits and collections, will appear in the December issue.

• A third-party payor is anyone other than the patient who assumes a responsibility, real or implied, for the payment of the bill incurred by the patient. It can be an individual, a partnership, or a corporation.

To assure payment, the hospital should obtain a signed agreement from the patient that he will be liable for the bill if third-party-payor relations are interrupted. In addition, there should be a definite promise to pay by the third party. This promise should be made by contract, preferably, since a contract protects this hospital if the patient is medically indigent or, for some reason, refuses to pay. The contract may stipulate payment for a series of cases over a specified period of time, as does the type of agreement used by the National Foundation for Infantile Paralysis, or it may cover only an individual case.

The Appellate Court of California has held that a patient is primarily responsible for his own bill, regardless of any relationship that might be superimposed upon the hospital by common law or customary practice. This would include a situation whereby a patient might be covered by the Workmen's Compensation Law of any state. Unless and except there is an individual specific contract between said insurance company and the hospital, there is otherwise no privity of contract which would require the hospital to accept less than its established retail rate.

A third party's liability to the hospital may be merely for the payment of a certain dollar amount (indemnity or cash benefit) toward the charges for services rendered. Such liability does not require a contractual arrangement between hospitals and third-party agencies, except for such matters as extension of credit to patient or authority to make payments directly to the hospital.

In some instances the third party agrees to pay "full costs." There is often a question as to what constitutes full costs. Cost can be defined simply as the outlay of money required for the complete operation of the hospital. It is an accounting definition and takes into consideration intangibles which are true costs and yet which do not involve the actual payment of cash at the time the transaction occurs. It should include reasonable amounts for medical and nursing education not otherwise covered by grants, tuition, or other fees. This recommendation is particularly applicable to institutions that have a nursing school or internship or residency program.

Full cost should include such items as interest on indebtedness, bad debts, depreciation, a reasonable value for the donated services of the sisters, charity losses, cost of research projects, and rent paid on any building or land used for hospital purposes.

Two controversial items are bad debts and depreciation. A prime reason for the honest differences of opinion on the inclusion of bad debts is the fact that bad debts are recognized almost universally as expense in any commercial operation. But the commercial business is under no obligation to render free service to anyone, while hospitals exist for the sole purpose of taking care of whatever patients may be brought to their doors.

The fact is well established that in any third-party relationship the hospital is entitled to recover its cost. Therefore, in the case of an uncollectible account, the hospital has already recovered its cost of servicing the patient—through such items as payroll costs, medicine charges, depreciation, and overhead cost. To permit the hospital to again recover the cost—plus its mark-up—is simply not a logical procedure.

There is one exception to this theory. Many Blue Cross plans reimburse their member hospitals on cost less amounts charged to patients who are not benefits of the contract. Therefore, if the hospital is unable to collect any portion of the bill covered by Blue Cross, it has failed to recover its cost by exactly that amount. This special factor should be taken into account by the Blue Cross plans and allowances made for it. Bad debts, therefore, should be treated as a reduction of income and not as an expense.

The provision for the replacement of equipment and building is just as much an item of cost as nursing salaries.

(Continued on next page)

*Administrator, La Mesa (Calif.) Community Hospital, and former chairman, Community Hospital Section, Assn. of Western Hospitals.

Any business must be able to retain out of profits an amount to replace its productive facilities. This amount is cost, and its importance has been emphasized in Bulletin No. 43 of the American Institute of Accountants. Depreciation may or may not be funded.

TYPES OF INSURANCE

There are many types of insurance that propose to pay hospital costs.

Group Insurance:

In the interest of good public relations, patients covered by group insurance should be admitted upon proof that certain benefits will be paid and that the insurance is in force. Hospitals should ascertain beforehand, however, the exact benefits payable. For example, in most instances these policies provide for $10 a day plus a total of $200 for all charges. Determining the exact benefits will enable the admitting office to inform the patient that there will be a balance due and payable upon discharge.

In every instance an assignment of benefits must be taken from the patient. Otherwise, the insurance company or third-party payor would pay the patient directly, and experience has proved that the hospital would have a difficult time recovering its bill.

Commercial Insurance:

While group-insurance patients should be admitted without a deposit, persons with commercial insurance policies should not receive the same preferential treatment. It should be borne in mind that commercial insurance companies have accepted the challenge imposed upon them by Blue Cross solely because Blue Cross led the way and increased the coverage and brought the premium down. Every effort should be made by the admitting personnel or any person involved in patient relations to point out that Blue Cross is still the pre-eminent form of coverage.

Public-Liability Insurance:

This form of insurance should never be accepted unless it cannot be avoided. The history of liability insurance, insofar as it applies to individuals, is a sorry one. Since the damages offered by the insurance company are seldom, if ever, equal to the desires of the plaintiff or his attorney, endless litigation results, and the hospital must wait until it is settled.

Compensation Insurance:

Compensation insurance companies generally try to pay less than the hospital's retail charges. However, on the basis of the previously-mentioned decision of the Appellate Court of California, which will probably be followed in most jurisdictions, it becomes necessary only to file a notice with each individual compensation insurance company that the hospital intends to bill all patients at its full retail price.

The notice should state further that the hospital is not concerned particularly whether the compensation company pays the full charge or a portion. The difference, if any, will be collected from the patient. The experience in California has been that it is necessary only to file one suit against a patient and no further difficulty will be experienced.

Since these insurance companies are organized for profit, it is to be expected that they will attempt to drive the hospital bill down. Some companies use high-sounding phrases, such as "Schedule established by Industrial Accident Commission." As a result of these companies' efforts, millions of dollars rightfully belonging to hospitals have been withheld from them.

Collections from Insurance Companies:

Under no circumstance should an unpaid assigned hospital account be allowed to stand on the hospital books in excess of 30 days. The insurance company should be notified immediately at the expiration of this period that the hospital cannot afford to wait any longer for its money and will collect from the patient.

Any amounts due over and above the amount to be paid by the third-party payor should be collected upon the patient's discharge.

The public relations of the hospital is best served by making prompt collections, thus keeping operating revenues at their proper peak for efficient operation of the institution. Some hospitals which have been forced to turn to the public for funds have been severely criticized because of a lax collection policy.

BLUE CROSS PLAN

The major difference between Blue Cross and other insurance is that Blue Cross is a service plan, whereas most commercial insurance policies are indemnity plans. The Blue Cross plan envisions complete health, surgical, and medical coverage for its insured under the broadest possible policies. It attempts to operate with approximately 10 percent for overhead costs and another 10 percent for reserves, leaving 80 percent to be spent for patient care.

The commercial companies, on the other hand, attempt to limit their service benefits to probably not more than 60 percent of the premium dollar. Thus, it is obvious that the Blue Cross plan offers the greatest insurance bargain in the country today. When this fact is coupled with the fact that Blue Cross and Blue Shield have the unqualified backing of hospitals and the medical profession, it should be simple for Blue Cross to command the greatest share of the market. Unfortunately, it seems content to rest on what it already has, not realizing that our economy is dynamic, not static. It can only go one direction—forward.

Another difference is that Blue Cross has a contract with the hospital, so that the patient's bill may be sent directly to Blue Cross. The person with commercial insurance, on the other hand, often must pay his hospital bill and then seek reimbursement from his insurance company. Blue Cross should exploit this advantage to the utmost.

There are a number of areas in which the relations between Blue Cross and the individual hospital can be considerably improved. Problems include admitting procedures, explanation for various contracts that are sold, the matter of claim rejections, rejections for admission for diagnosis only, co-insurance on some contracts involving drugs and medications, and payment of claims. The plans which are successful and which enjoy the best possible hospital relations are aware of these problems and are working aggressively toward solving them.

Blue Cross Admissions:

There has often been criticism of the Blue Cross admission procedure. Too frequently forms require time and are so cumbersome that the average employee instinctively puts them aside until the last. Blue Cross has to have certain data, yet it has been the experience of the good plans that the data needed can be condensed into a few items. Snap-out forms with one-time carbons should be provided, so that a minimum of work is required by the hospital admitting personnel.

To establish whether the patient is covered and to enable Blue Cross to inform the hospital as to the extent of coverage, it is probably sufficient for the form to request the contract number, the group number, the name of the insured, the name of the contract holder, the admitting diagnosis, and the date and time of admission. Certain other data will be required upon discharge.

One big problem involving Blue Cross is the mutiplicity of contracts which many plans sell. The average person who has Blue Cross is not insurance-minded. He does not understand what he is covered for and what he is excluded from. For example, he does not understand co-insurance, in which he is required to pay a certain percentage of his drug bill. He does not understand that the Blue Cross plan presupposes a ward bed or a semiprivate bed and that he has to pay extra for a private room.

EXTENT OF COVERAGE

The Blue Cross plan should provide the hospital with some form of manual which is clearly marked and which indicates every type of contract that is sold or in effect in a particular area, in order that the admitting-office personnel may determine as soon as the Blue Cross card is presented the extent of the coverage and explain to the patient that his bill will be entirely covered by Blue Cross or that an additional balance will be due upon discharge. Areas in which plans provide such manuals have the best relations among the hospitals, the patient, and the plan. Everybody knows where he stands when the Blue Cross patient comes into the hospital.

Blue Cross Rejections:

Inevitably cases will be presented in which the insured has allowed his policy to lapse, is not covered for the particular diagnosis, or is not eligible for some other reason. Blue Cross is as anxious as the hospital to make certain that the maximum number of people are covered, but it cannot legally or in justice to its other policyholders pay a claim for which the insured has no coverage.

As soon as Blue Cross determines that the patient is not covered for the particular admitting diagnosis, it should inform the hospital as fast as possible. Even if a long-distance telephone call is necessary, the money is well spent in maintaining good relations between the plan and the hospital. Telegrams may be used if delivery is reasonably prompt. In any event, the hospital should not be left dangling for four or five days until the matter of coverage is determined.

One of the principal reasons for rejections is admission for "diagnosis only." The obvious answer to this problem would be for Blue Cross to include, in its contract provisions, allowance for one or two diagnostic admissions each year. It is well known that patients are coming into the hospitals anyway and receiving diagnostic treatment. Why not legalize it and help the doctor, the patient, and the hospital? If this step does not prove feasible, the hospital, in securing submitting diagnosis, should attempt to ascertain whether the patient is being admitted for diagnostic purposes only.

Cooperation of the attending physician is essential. Many doctors take the position that they should bring their patients in and give them extensive x-ray tests, because hospitalization is more convenient, because the patient doesn't feel much like walking after some of the tests—and because Blue Cross will pay the bill. If Blue Cross still feels that it cannot pay for this type of service, then the hospital and the doctor should work together, through the joint conference committee, toward eliminating as much of this as possible. Blue Cross can cooperate by processing the admitting form as rapidly as possible and asking for further clarification if the admitting diagnosis indicates the patient might be in for diagnostic tests only.

Drugs and Medications on a Co-Insurance Basis:

Payment for drugs and medications on a co-insurance basis is a source of much annoyance to the patient and to the hospital. Rarely are significant amounts involved, but a strain is put on good hospital relations when the patient who previously had thought his bill was paid in full is presented with a bill for $5.71 as the excess charge for drugs over a certain amount.

It is probably correct, from an actuarial standpoint, that contracts should be written with this provision in them. However, Blue Cross, through its representatives, should make every effort to explain to subscribers that this feature is in the contract and that they will be expected to pay a very small portion of the bill upon leaving the hospital.

Emphasis can and should be put on the fact that the major portion of the bill, in most cases better than 95 percent, has already been paid by Blue Cross and that this is only an unpredictable portion which the patient should himself pay.

Blue Cross could help the hospital eliminate this annoyance by providing admitting clerks with complete information on all contracts which the plan offers in the particular area, including the so-called "inter-plan" cases, which involve treatment of a patient from one plan in an area of another plan. If admitting officers had information available so that they could check the subscriber's type of contract against what the plan offers, the admitting officer could explain to the patient at that time that there will be a certain amount to be paid upon leaving the hospital.

Payment of Claims:

It must be recognized that any plan as large as most Blue Cross plans requires a certain amount of paper work and red tape. Blue Cross has to be certain, of course, that the claim is just, is covered by the contract, and that the subscriber is actually a paid-up member of that particular plan. This takes time. Even though the admitting sheet has been screened, the claim form must still be double-checked. The amounts billed must appear to be in line with the type of service rendered. If surgery has been performed, the name of the surgeon and the anesthetist must be shown, together with time of anesthesia and time of operation.

PAYMENT OF CLAIMS

There are many things that must be checked. However, it is entirely feasible with proper organization in the Blue Cross office itself to make reimbursement to the hospital on more frequent intervals than once a month. One very large West Coast plan is now reimbursing its hospitals every seven days. A check is mailed out on Friday of each week for claims processed through Wednesday. Inasmuch as most plans operate on a basis of partially reimbursing the hospital on certain percentages of its retail billing, it is always possible to adjust on subsequent remittances any overpayments or underpayments which occurred in a previous remittance.

Few hospitals today have excess money in their bank accounts. Therefore, it is essential that Blue Cross do everything possible to speed the payment of its just claims

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to its member hospitals. A few plans can do it. The rest should certainly follow suit.

The hospital should immediately prepare the claim portion of the admitting notice as soon as the patient has left the hospital. Information is now available as to all charges. Any well-run hospital should have procedures set up so that it will be immediately notified of late charges. This information should be in the business office at least prior to the time that the patient has actually left the hospital. In any event, the claim form should be prepared and should be mailed the same day the patient leaves the hospital.

INDOCTRINATION COURSES

Complete information should be provided. The plan should not be required to enter into further correspondence with the hospital and ask for further data as to the procedure done (surgical or medical), time, and other items.

Blue Cross could help hospitals a great deal by arranging, at more or less frequent intervals, courses of indoctrination for admitting and business-office personnel involved in admitting and billing Blue Cross patients. Skilled persons from the plant itself can suggest many short-cuts and can acquaint hospital personnel with the problems facing Blue Cross and with processing claims. This mutual cooperation will greatly assist the prompt processing of claims, which should be followed by prompt remittance to the hospital by the agreed-upon method of reimbursement.

Day Stay of Blue Cross Patients:

Surveys made in a number of areas seem to indicate that patients covered by insurance tend to stay on an average longer than private patients. Whether this has happened by chance or by design, it is hard to say. Nevertheless, statistics seem to bear out the fact that there is an extra penalty or charge involved if the patient has Blue Cross.

As everyone agrees that it costs money to provide this extra stay, both the hospital and the attending physician should do everything possible to eliminate any extra stay beyond the medical necessity of the particular case. With costs increasing as they are for legitimate reasons, the further unnecessary burden of an extra day's stay can only force the Blue Cross plan to increase its premium, thereby inevitably forcing out some of the lower wage groups.

Education of both patients and medical staff is necessary to solve this problem. As it is easier to contact a medical staff, the administrator should arrange a series of meetings of the staff and frankly point out the problem involved. Blue Cross representatives should be invited to attend, with permission of the staff, of course, and explain graphically the effect of an extra day's stay on cost and its direct effect on rates that Blue Cross has to charge.

In those areas which have some sort of organized program under way to combat this evil, the program has had much success. However, it is sad to relate that many areas, like the ostrich which sticks its head in the sand, choose not to admit that the problem exists. It does exist, and with concerted effort it can be licked. There is no reason that Blue Cross or, for that matter, commercial insurance, should be forced to stand an extra charge which is not medically necessary.

GOVERNMENT RESPONSIBILITY FOR INDIGENTS

An indigent is ordinarily understood to be a person without financial resources. However, to be entitled to medical assistance, a person does not necessarily have to be completely destitute or dependent on charity. A dis-

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tinction must be made between those with financial resources inadequate to meet the basic necessities of life and those who can maintain a basic standard of food, shelter, and clothing, but who cannot pay for medical care. The first group are indigents; the second are medical indigents. The law contemplates that the authorities provide a measure of relief for sudden misfortune which could occur through sickness or physical injury.

The common law places upon the officials of the local political subdivision the responsibility for the care of all indigent persons within its borders. The responsibility is purely a local problem, although in some instances it has been assumed by the federal government for persons suffering from Hansen's disease or narcotic addiction. In some cases—particularly psychiatric cases—the responsibility belongs to the state.

ADMINISTRATOR RESPONSIBILITY

However, there is no common-law obligation for a political subdivision to pay for hospital services rendered to an indigent in an institution other than the government's own institution. The county, township, or city, or whatever the subdivision, may be responsible only to the extent it is made so by statute or charter or ordinance. It should be the responsibility of each administrator to study carefully the law pertaining to the medically indigent in any general statement which will be basic throughout the United States.

A recent study of the medical-care activities of local government was complicated by the fact that a large number of political subdivisions (there are 3,070 counties in the United States and 35,000 governmental subdivisions of these counties) within a state are responsible for providing certain types of medical care, and that within these subdivisions several agencies may share the responsibility. Additional complications arise from the incomplete reporting systems that may not extend beyond the local level. There is also divided responsibility between state and local governments in rendering medical services, with the additional complication that funds may be supplied from federal and state as well as local sources.

CLASSIFICATIONS OF INDIGENTS

One of the first studies of this problem of the medically indigent was undertaken by the Commission on Financing of Hospital Care in the United States. It was the conclusion of the study that regardless of the precise point at which the line is drawn between those economic groups that can and cannot pay for hospital care, through prepayment or otherwise, there are a significant number of persons in the United States who cannot be expected to pay for care. The problem is constantly growing because one group that consistently contributes to the medically indigent includes unemployed persons in the older-age brackets and their dependents—also unemployed. Due to the over-all increase in the life span, their number is ever increasing.

Included in medical indigents are temporarily unemployed persons and their dependents, the disabled and their dependents, persons with income insufficient to buy both daily necessities of life and hospital care, and lastly persons receiving public aid.

Some idea of the tremendous problem facing the voluntary hospital can be obtained if one considers the fact that older people as a group require more hospital services and are less able to pay for hospital care. With the advances in diagnosis and therapy, it can be expected that there will be an increase in the utilization of hospital services by the older age groups—generally defined as persons 65 years of age or over.

(Continued on next page)

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The Commission on Financing of Hospital Care arrived at several conclusions. From the vast mass of data which they assembled, it was apparent that the only solution for the care of these medical indigents was some form of prepaid hospital and medical insurance. The Commission collected some statistics which seem to indicate that it would probably be cheaper to pay for some form of prepaid hospital care, such as Blue Cross, than to offer the same service to the patient by the governmental unit.

Some validity to this theory has been given by the government in its recent decision to provide care outside of service hospitals for the dependents of those on active duty, through the Medicare program. It was found considerably cheaper for the government to arrange for payment for these cases to the private hospital, less a deductible fee of $25, than to further extend service hospitals, which were primarily built and maintained for the care of men in the armed forces.

Voluntary hospitals should carefully study this problem and assist their local, state, regional, and national hospital associations in working toward a solution. If the medically indigent group continues to increase at the same rate as it has in the last decade, it can be readily predicted that in the next 20 years nearly 50 percent of all patients in the voluntary hospitals will be in this classification. There will be the additional problem of finding beds, but the main problem will be the financing of care for this tremendous segment of our population without means to pay for their own care.

It should be routine procedure in all hospitals that the admission office or whoever sees the patient for the first time should make an effort to determine the financial responsibility for every patient. Charity to needy patients is not and need not be the sole purpose of the hospital. Along the same line of thought, it could be stated that the modern hospital does not necessarily confine itself to the care of the sick alone. It aids to a considerable extent the education of nurses, doctors, community organizations, and the public. Also, it is extensively engaged in research into the cause and cure for disease and methods of prevention.

A hospital that performs these additional functions measures up to the legal conception of a charity or benevolence. Therefore, the statement that it is the responsibility of all voluntary hospitals to care for needy patients is not correct. The hospital may not refuse emergency and needed care to anyone brought into its doors, regardless of the financial ability of the patient to pay. However, as soon as emergency care is given, the hospital has a responsibility to its community to make every effort to secure payment for the services which have been rendered. Any other method of operation would simply invite bankruptcy.

When it is apparent that the patient does not have adequate funds to pay for his hospitalization, the hospital immediately has the responsibility of determining the legal residence of the patient and making a prompt claim upon the authorities of that political subdivision for payment for the care rendered.

As soon as emergency care of the patient who appears to be medically indigent is assumed by the hospital, it is essential that prompt steps be taken to determine as soon as possible what the welfare authorities intend to do about the payment of a bill. Public officials must either accept responsibility or present a valid reason for not doing so. Their excuses for refusing payment might be the ability of responsible relatives to pay, coverage by accident insurance or Workmen's Compensation, or perhaps a lawsuit arising out of the accident or otherwise.

Prompt action by the hospital is very important. It has been held that if services are rendered by a hospital without permission from any authorized welfare official, it must appear that an emergency existed which rendered it impossible to await authorization and that the situation was promptly reported to the official. However, if the hospital does nothing and the patient is still in the hospital past the emergency period, there are ruling cases to the effect that the county has no further responsibility for the care of the patient in the voluntary hospital.

ASSIGNMENT OF RESPONSIBILITY

The welfare authorities should be advised of every step of the patient's progress, even if a daily report of the patient's condition is necessary. A number of cases have been lost by hospitals which failed to take into account that the law requires welfare authorities to be constantly on notice as to the status of the patient whom the hospital may claim to be medically indigent and for whom the hospital may claim reimbursement from the political subdivision.

The safest procedure for the hospital to follow is to insist that the local government office notify the hospital in writing of its intention towards a particular case. The hospital cannot rely with impunity on any oral promise to pay. It sometimes happens that the government official who orally promised to pay has no legal authority to bind his governmental unit.

The hospital has a responsibility to make every attempt possible to locate sources by which the hospital's bill may be paid or relatives who have a legal responsibility to the patient. It has been said that a hospital treating a medical indigent is in effect placing itself in the position of the governmental unit, which, should it have custody of the patient, would make every effort to locate funds or responsible relatives. The hospital should therefore have evidence at hand that it has made an attempt to either locate funds or responsible relatives. The records should also clearly indicate that the case is not covered by Workmen's Compensation and that the hospital insofar as it is able to determine, has no knowledge of a liability assumed by someone else resulting from the accident to the patient.

In other words, the hospital should make as vigorous an effort as possible to insure that the governmental agency will pay the bill. This promise to pay does not necessarily relieve the hospital of its liability to locate sources of funds.

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Ready Reference of Hospital Facts

For Planning and Operation

Part XXI

By Louis Block, Dr. P.H.

Federal Mental Hospitals in the United States*

● From 1946 to 1954 the activities of the federal hospitals in the United States have shown some marked changes, especially in the number of facilities available, their utilization, finances and personnel. These hospitals now account for 6.2 percent of all hospitals; 12.0 percent of all beds; 11.9 percent of the average days of care provided; 7.0 percent of all admissions, and 17.7 percent of all expenses.

Facilities:

1. The number of hospitals has increased by 26 (from 404 to 430)—an increase of 6.4 percent.

2. The number of beds has decreased by 46,731 (from 235,964 to 189,233)—a decrease of 19.8 percent.

Utilization:

1. The average daily census has decreased by 6,837 (from 166,356 to 159,519)—a decrease of 4.1 percent.

2. The percentage of occupancy has increased from 70.5 percent to 84.3 percent.

3. The number of admissions has decreased by 172,819 (from 1,593,335 to 1,420,516)—a decrease of 10.9 percent.

Finances:

1. Total assets have increased $993,121,000 (from $811,630,000 to $1,804,751)—an increase of 122.4 percent.

2. Total expenses have increased $553,793,000 (from $372,960,000 to $926,753,000)—an increase of 148.5 percent.

3. Total expenses per patient day have increased $9.78 (from $6.14 to $15.92)—an increase of 159.3 percent.

4. Payroll expense has increased $455,483,000 (from $246,795,000 to $702,278,000)—an increase of 184.5 percent.

5. Payroll expense per patient day has increased $8 (from $4.06 to $12.06)—an increase of 197.0 percent.

Personnel:

1. The number of full-time personnel has increased by 32,607 (from 161,925 to 194,532)—an increase of 20.1 percent.

2. The number of full-time personnel per 100 patients has increased by 25 (from 97 to 122)—an increase of 25.8 percent.

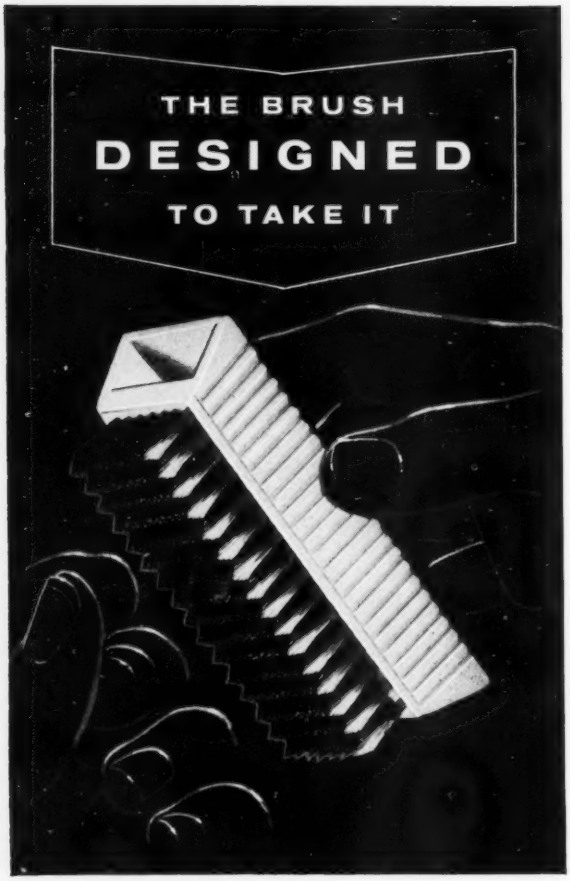
Following are some pertinent facts concerning the average federal mental hospital in the United States.

The Average Federal Mental Hospital in the United States*

Facilities:	
1. Number of beds	1,532
Utilization:	
1. Number of annual adult admissions	1,138
2. Average daily adult census	1,437
3. Percentage occupancy	93.8
4. Average length of adult stay in days	460.8
Financial:	
1. Total assets	$7,290,214
2. Plant assets	$7,252,786
3. Percent plant assets of total assets	99.5
4. Total annual expenses	$4,983,929
5. Total expenses per patient day	$9.50
6. Annual payroll	$3,835,690
7. Payroll per patient day	$7.31
8. Percent payroll of total expenses	76.9
Services:	
1. Percent of hospitals offering:	
a. Blood bank	32.5
b. Cancer clinic	10.0
c. Central supply room	90.0
d. Children's education program	0
e. Clinical laboratory	100.0
f. Dental department	100.0
g. Electrocardiograph	100.0
h. Electroencephalograph	100.0
i. Hospital auxiliary	47.5
j. Library, medical	100.0
k. Library, patient	100.0
l. Medical record department	100.0
m. Mental hygiene clinic	7.5
n. Metabolism apparatus	100.0
o. Occupational therapy department	100.0
p. Outpatient department	25.0
q. Pharmacy	100.0
r. Physical therapy department	100.0
s. Postoperative recovery room	67.5
t. Premature nursery	0
u. Radioactive isotopes	0
v. Rehabilitation department	100.0
w. Social service department	100.0
x. X-ray diagnosis	100.0
y. X-ray, routine chest, on admission	100.0
z. X-ray therapy service	17.5
Personnel:	
1. Number of full-time personnel	1,015
2. Number of full-time personnel per 100 patients	71

*Based on information in American Hospital Association's Administrators Guide Issues (1951-1955).

(Continued on next page)



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3.	**Nursing personnel:**	
	a. Total graduate nursing personnel	80
	(1) Administrative graduate nursing personnel	3
	(2) Full-time instructors	2
	(3) Supervisors and assistants	6
	(4) Head nurses and assistants	18
	(5) General-duty nurses, full-time	49
	(6) General-duty nurses, part-time	1
	(7) Nurses not classified	1
	b. Private-duty nurses	0
	c. Practical nurses	6
	d. Attendants	329
	e. Nurses' aides	166
	f. Ward maids	0
	g. Orderlies	10
4.	**Medical technologists:**	
	a. Registered, full-time	1
	b. Registered, part-time	0
	c. Other full-time	5
	d. Other part-time	0
5.	**X-ray technicians:**	
	a. Registered, full-time	1
	b. Registered, part-time	0
	c. Other full-time	2
	d. Other part-time	0
6.	**Occupational therapists:**	
	a. Registered, full-time	4
	b. Registered, part-time	0
	c. Other full-time	3
	d. Other part-time	0
7.	**Physical therapists:**	
	a. Registered, full-time	2
	b. Registered, part-time	0
	c. Other full-time	2
	d. Other part-time	0
8.	**Dietitians:**	
	a. Full-time	6
	b. Part-time	0
9.	**Medical social workers:**	
	a. Full-time	7
	b. Part-time	0
10.	**Pharmacists:**	
	a. Full-time	2
	b. Part-time	0
11.	**Medical record librarians:**	
	a. Registered, full-time	1
	b. Registered, part-time	0
	c. Other full-time	1
	d. Other part-time	0
12.	**Other medical record personnel:**	
	a. Full-time	13
	b. Part-time	0

DEPARTMENTAL

Medical staff:

1.	Percent hospitals accredited by the Joint Commission on Accreditation of Hospitals	83

Administrator:

1.	Percent hospitals having administrative staff member on duty at night	64.9
2.	Percent hospitals delegating administrative responsibility to night supervising nurse	21.6

Laboratory:

1.	Percent hospitals having urinalysis on all admissions	97.1

2. Percent hospitals having blood count on all admissions	88.6
3. Percent hospitals having serological examinations for syphilis on all adult admissions	94.3
4. Percent hospitals having electrocardiograms on all admissions over 45 years of age	37.1
5. Percent hospitals having Rh grouping on all pregnancy cases	14.3
6. Percent hospitals having preoperative blood groupings on all surgical cases	74.3
7. Percent hospitals having preoperative coagulation on all tonsillectomies	77.1
8. Percent hospitals having post-operative urinalysis on all surgical cases	65.7
9. Percent hospitals having no tests without doctors' orders	2.9

Outpatient Department:

1. Number of annual clinic visits	319
2. Number of annual private outpatient visits	0
3. Number of annual emergency visits	54

Medical Records:

1. Number of annual deaths	54
2. Number of annual autopsies	36
3. Percent autopsies of deaths	67.4
4. Number of annual deaths released to legal authorities	3
5. Percent hospitals using Standard Nomenclature of Diseases and Operations	100.0

Admitting:

1. Percent hospitals routinely treating the following types of patients:	
a. Alcoholics	34.1
b. Cancer	29.3
c. Cardiac	34.1
d. Dermatologic	29.3
e. Drug addiction	24.4
f. Epileptic	63.4
g. Gynecologic	12.2
h. Isolation (Contagion)	14.6
i. Leprosy	0
j. Medical	48.8
k. Mental deficient	39.0
l. Neurologic	63.4
m. Obstetric	0
n. Ophthalmic	26.8
o. Orthopedic	29.3
p. Otorhinolaryngologic	24.4
q. Poliomyelitis	9.8
r. Psychiatric	100.0
s. Surgical	48.8
t. Tuberculosis	29.3
u. Urologic	26.8
v. Venereal Disease	12.2
w. Acutely ill	89.7
x. Chronically ill	97.4
y. Students exclusively	0
z. Convalescent and rest	5.1
aa. Geriatric	46.2
bb. Industrial	2.6
cc. Pediatric	0
dd. Prisoners exclusively	0

Accounting:

1. Percent hospitals operating under formal budgets	86.8
2. Percent hospitals using AHA chart of accounts	2.8

Public Relations:

1. Percent hospitals using patient opinion poll	2.7
2. Percent hospitals using personnel opinion poll	21.0
3. Percent hospitals using medical staff opinion poll	13.5
4. Percent hospitals using community opinion poll	2.7
5. Percent hospitals using none of these	75.7

Laundry:

1. Percent hospitals operating own laundry and processing all soiled linen	100.0
a. Number of pounds processed per week	52,566
b. Number of pounds processed per patient day	5.8
2. Percent hospitals operating own laundry and processing only a part of soiled linen	0
a. Number of pounds per week	0
b. Number of pounds per patient day	0
3. Percent of hospitals not operating own laundry	0
a. Number of pounds processed per week	0
b. Number of pounds processed per patient day	0

Auxiliaries:

1. Percent hospitals having organized auxiliaries	67.5

Safety:

1. Percent hospitals having own written plan for mobilization of employees and medical staff	97.4
2. Percent hospitals whose written plan is integrated in master community plan	66.7
3. Percent hospitals represented on a community disaster planning committee	63.2

Religious:

1. Percent hospitals with a chapel	97.5
2. Percent hospitals with a meditation room for prayer	66.7
3. Percent hospitals with organized visiting clergy staff	32.4
4. Percent hospitals having chaplains available	100.0
5. Percent hospitals with full-time chaplains	90.0
6. Percent hospitals with part-time chaplains	7.5
7. Percent hospitals with chaplain on call only	0

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Review of Hospital Law Suits

by Leo Parker

Attorney at Law

• Right of Burial Defined

• Rescinding of Fraudulent Contracts

• When and under what circumstances may a body be removed from a grave and interred into another grave or cemetery? Who has the lawful and legal right to designate where the body of a deceased shall be interred?

Modern higher courts consistently hold that the right of burial ordinarily includes the right to determine the time, manner, and place of burial. It is the policy of the law, except in cases of necessity or for laudable purposes, that the sanctity of the grave should be maintained, and that a body once suitably buried should remain undisturbed, and a court will not ordinarily order or permit a body to be disinterred unless there is a strong showing that it is necessary. When a burial is made by the consent of those having the paramount right, the grave is regarded in law as a final sepulcher which cannot be disturbed against the will of those who have the right to object, except upon strong and convincing evidence of new and unforeseen events occurring since the burial which show that it would be unreasonable to refuse the removal.

See People v. Harvey, 286 Ill. 593. In this case the Supreme Court said:

"Right of possession of a dead body in the absence of any testamentary disposition belongs usually to the husband or wife, or next of kin."

In Palenzke v. Bruning, 98 Ill. App. 644, at page 650, the court explained that while it may be true that there is no right of property to a dead body, it is also true that the nearest relatives of the deceased are, except under ecclesiastical law, legally entitled to its custody and to lay it away in burial. It is the duty no less than the right of such relatives to protect it from unnecessary violation, and any infringement upon that right, except where made necessary for the discovery and punishment of crime, violates the tenderest sentiments of humanity.

On the other hand, the higher courts very consistently hold that if in his will a person specifies where his body shall be interred, this provision of the will must be followed whenever it is practical to do so. However, once the body is interred in disregard to the will it cannot be removed.

In Fischer's Estate v. Fischer, 117 N. E. (2d) 855, the testimony showed that William Carl Fischer of Chicago made his last will in which he directed that his just debts, funeral expenses, and hospital expenses be paid by his executrix; that he be buried in a certain lot in Graceland Cemetery; and that the executrix have sole charge of the interment. He appointed his sister as executrix of the will. He died soon afterward, and his widow, Anna, caused the body to be interred in Rosehill Cemetery.

A few days later the will was filed in the probate court, and the sister learned that her brother had in his will requested that his body be buried in Graceland Cemetery. Four years later she filed suit and asked the court to allow the removal of the body from Rosehill Cemetery for burial in Graceland Cemetery. The sister maintained that her brother had the right to direct the place of his interment and that it was her duty to enforce that provision of the will.

The court refused to allow the sister to remove the body.

WHAT IS TREATMENT?

A hospital official recently asked the writer to define the legal meaning of the word "treatment." He said that at present the outcome of a very important lawsuit depends upon the legal meaning of this word. I made an extensive review of late and leading higher-court decisions and located a decision rendered in 1955 which clearly answers this question.

In Dr. David Gordon Petty v. Dr. Lillard Sloan, 277 S. W. (2d) 355, it was shown that county commissioners and certain physicians signed a contract by the terms of which the county constructed a hospital. The contract specified that the doctors agreed to cooperate with all reputable doctors in operation of the hospital and to make available the facilities of the hospital for "treatment" of their patients.

Later it was contended that it was the doctors' intent that the word "treatment" should be used in a restricted sense and should not include surgical operations.

In subsequent litigation, the higher court held that the word "treatment," as used in the contract between the county, which had constructed the hospital, and the lessee doctors, covered all steps taken to effect a cure of injury or disease, and included surgical operations. The court said:

"It certainly seems that in construing the meaning of the word 'treatment' it should be given its ordinary meaning. The courts have held that the word 'treatment' in common parlance and often in law is a broad term covering all the steps taken to effect a cure of an injury or disease."

This court went on to explain that the word "treatment" includes three stages—preliminary, main, and final—and whatever is usually done to the patient or administered

to him by a skilled physician or surgeon in any one of these stages is properly included under the term "treatment," even though it may not be an indispensable prerequisite.

CEREBRAL HEMORRHAGE IS ACCIDENT

According to a late higher-court decision, an employee who suffers a cerebral hemorrhage is entitled to recover damages or compensation under the State Workmen's Compensation Act, if the evidence showed that the employee was overworked.

In Threshermen Insurance Co. v. Gilliam, 76 S. E. (2d) 834, the testimony showed that Gilliam, 64, worked for his employer from 8:30 a.m. until 10 p.m. and had to lift heavy loads.

A physician testified: "The man (Gilliam) had what we call a cerebral accident, and that covers a lot of territory. . . . I think the man had had a cerebral hemorrhage or stroke."

On the basis of the physician's testimony, the higher court awarded Gilliam compensation because of overexertion, saying:

"The diagnosis and treatment of injury and disease are essentially medical questions to be established by physicians as expert witnesses and not by laymen. The accident and injury was the result of overexertion in his (Gilliam's) work and while so employed he sustained an accidental injury which arose out of and in the course of his employment resulting in his total disability."

RESCINDING FRAUDULENT CONTRACT

Modern higher courts consistently hold that a contract based on fraud is rescindable. Moreover, the defrauded contracting party has a reasonable period of time in which to rescind the contract.

In Telex, Inc., v. Schaefer, 233 Fed. (2d) 259, the testimony showed that Schaefer answered an ad in a Birmingham, Ala. paper in which it was stated that a franchise was available for the operation of Telex pillow radios in the Birmingham hospitals, for someone with $13,320 to $26,850 to invest. The ad led Schaefer to see a Mr. Scott, the Telex representative. Scott recommended Telex radios highly and painted a picture of easy money in large quantities from their use by hospital patients.

After considerable dickering Schaefer and Scott signed the contract, and Schaefer gave Scott his certified check for $27,839.87. Schaefer installed 302 radios in the Birmingham Baptist Hospital. Complaints began immediately. Defects in the radios of various kinds were evident from the start. Also, the amount of money paid into the radios by hospital patients was small.

On April 2, Schaefer learned that representations made by Scott were fraudulent. Schaefer waited, however, until August 23 to file a suit asking the court to compel Telex, Inc., to cancel the contract and return the $27,839.87. The higher court held in favor of Schaefer, and said:

> **"Appellee (Schaefer) had a reasonable time to rescind the contract on discovery of the fraud by Scott. There is no fixed rule as to time. What is reasonable must vary with the facts of each case . . . This suit was filed August 23. We cannot say, considering the circumstances, that from April 2 to August 23, was a delay sufficiently long to constitute a waiver and bar appellee (Schaefer) from recovery for fraud."**

(1)

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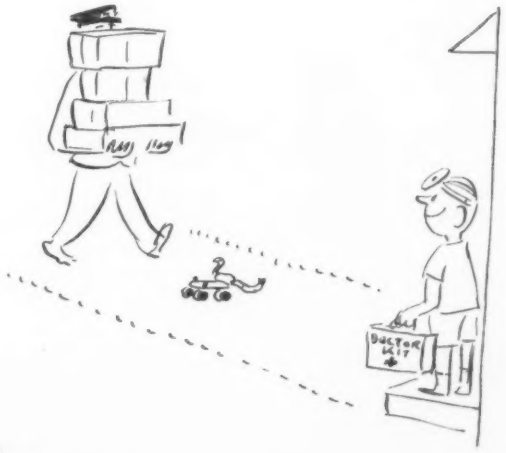

Con Svozzi

TRADE TOPICS . . .

Keefe, Rand Appointed To New Positions

James T. Keefe, Jr., has been named product manager, Sodasorb department, Dewey and Almy Chemical Co., division of W. R. Grace and Co.

Keefe

The firm has also appointed William M. Rand, Jr. sales manager of its Chemical Specialties Departments.

American Cyanamid Changes In Surgical Division Told

Four members of the surgical products division, American Cyanamid Co., have been named to new positions.

Harlan Prater, Jr., former president of MacGregor Instrument Co., which was recently acquired by Cyanamid, is now assistant to the general manager in charge of the MacGregor Instrument department. G. Philip Trumbour, former vice-president, MacGregor, is now manager of the surgical products division's instrument plants. David Housh, former MacGregor sales manager, is now field sales manager for the surgical products division, and E. John Larson is manager of sales training.

Shampaine Appoints Company Comptroller

The Shampaine Co. has appointed Fred Nielsen as comptroller-treasurer to succeed William Raby who returns to the teaching profession.

Nielsen

Before joining Shampaine, Nielsen was administrative assistant to the comptroller of Motorola, Inc., in Chicago.

Parke-Davis Names Four To New Positions

Carl Johnson, with Parke-Davis since 1931, has been promoted to assistant to the president, in charge of public relations. He was formerly United States and Canadian sales manager.

Other promotions in the company are Ralph G. Sickles, from director, advertising and public relations, to director, institutional advertising and publicity; George A. Bender, from retail promotion manager to assistant director, institutional advertising and publicity, and Walter L. Griffith, from manager, promotion department, to director, product advertising and promotion.

Puritan President Dies

Parker Browne Francis, board chairman, Puritan Compressed Gas Corp., died September 13, in Kansas City, Mo. He was 71.

He was a founder of Puritan in 1913, and president from 1932, until he assumed chairmanship in January, 1957.

He assisted various professional groups in setting up anesthesia societies and worked closely with them in the research, development, and use of medical gases.

Stanley Equipment Names New Sales Manager

The promotion of Jay P. Bruemmer from assistant sales manager to sales manager of the Stanley equipment division, Landers, Frary, and Clark, was announced by Stanley G. Fisher, vice-president of sales.

Bruemmer

Bruemmer joined the organization in 1948.

Pictured below, outside the Gomco Surgical Mfg. Corp. plant in Buffalo, N. Y., is the largest single export shipment ever made by Gomco to one hospital. Destined for Hospital Militaire, Caracas, Venezuela, the shipment included 115 suction pumps.

Seamless Rubber Forms New Hospital Division

The Seamless Rubber Co. has consolidated its surgical rubber and surgical dressings divisions into a new hospital division, according to Hal J. Barich, general sales manager.

Carson J. Morris, formerly director of marketing, Vitamin Corp. of America, laboratory division, heads the new division.

Robert Smith continues as manager, surgical rubber. Philip Hemphill has been promoted from assistant manager to manager, surgical dressings.

Cupo Heads New Hospital Division

Grant Pulley & Hardware Corp. has named Herbert F. Cupo as sales manager for its newly created hospital equipment division.

The division will handle hospital cubicle screening equipment and bathroom accessories.

Merger of Schering Corp., White Laboratories Announced

The merger of Schering Corp. and White Laboratories, Inc. into a single pharmaceutical company was announced recently by Francis C. Brown, president, Schering, and J. C. DeCesare, president, White Laboratories.

Schering becomes the parent corporation. White Laboratories and its subsidiary, Pharmaco, will continue to operate under their present names. Activities of Union Pharmaceutical Co., Schering's proprietary subsidiary, will be merged with those of Pharmaco.

Admiral Appoints Head For New Hospital Unit

Fred Petersen has joined Admiral Corp. as sales manager of the newly created hospital service division. He was founder-president of Petersen-Daniels, Inc. of California.

The division is part of Admiral's Molded Products facility in West Chicago, which produces disposable plastic products for hospitals and the medical field.

Harry Gilbert (l.), who accepted Hospital Industries' Association award given to E. F. Hauserman Co. exhibit during AHA convention, shows his plaque to John E. O'Neil, who accepted award presented to International Nickel Co., Inc. exhibit.

Best AHA Exhibits Honored by HIA

Top awards for excellence of technical exhibits were presented to the E. F. Hauserman Co. and the International Nickel Co., Inc. by the Hospital Industries' Association during the recent AHA convention in Atlantic City. The Hauserman exhibit was judged best in the 200 square feet and over category, and the International Nickel exhibit as best in the less than 200 square feet group.

A special award was presented to the Infant Formula Center, exhibit sponsored jointly by seven companies. Awards were presented by William E. Smith, executive director, Hospital Industries' Association.

Certificates of honorable mention were presented to Magic Door Sales, Division of Stanley Works, and the National Cylinder Gas Co., for booths in the 200 square feet and over category; and to Ethicon, Inc., and McKesson and Robbins, Inc., in the less than 200 square feet category.

Mrs. Trimbach investigates box held by Sister Fabiola, St. Joseph's Hospital, San Francisco, at open house marking opening of new Burroughs Wellcome & Co. West Coast branch office and warehouse, Burlingame, Calif. area hospital personnel attended.

5 REASONS FOR BUYING L/L. INTERS SYRINGES

L/L INTERS assure perfect interchangeability.

L/L INTERS provide uniform compression from tip to top, prevent back flow.

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10 cc.	30.00 doz.	33.00 doz.
20 cc.	39.00 doz.	42.00 doz.

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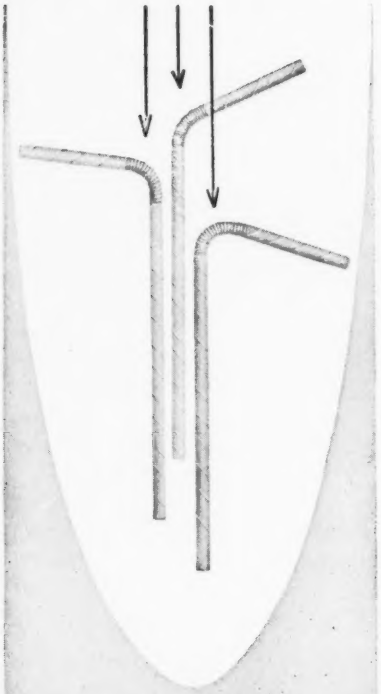

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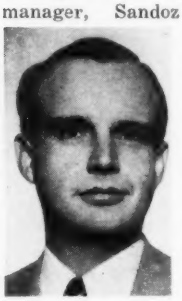
Sandoz Appoints New Market Manager

Filling the new post of marketing manager, Sandoz Pharmaceuticals, is Joseph R. Mason. He has also been appointed to the company's management committee.



Mason

Mason has been sales manager of Sandoz Pharmaceuticals since 1955.

Johnson & Johnson Appoints Sales Manager

William B. Borsdorff has been named acting manager of Johnson & Johnson's hospital division.

With the company 11 years, Borsdorff was assistant field sales manager, hospital and surgical supply house dealers division, prior to his new appointment.

Borsdorff

News Briefs

Robert D. Smith—has been appointed vice-president and general manager, Mystik Adhesive Products, Inc., Chicago.

Catherine H. Roth, M.D.—has recently joined Winthrop Laboratories as associate medical director. She was previously in charge of medical educational services and medical advertising for Merck, Sharpe & Dohme, International.

Noel H. Wallen — has been elected president and general manager, Cameron Surgical Specialty Co. **Alex S. Cameron, M.D.**—has assumed the new post of chairman of the Cameron Co. board.

Thomas C. Fleming, M.D.—has been named director, clinical research, Mead Johnson & Co. Dr. Fleming was previously with Roche Laboratories.

D. Wayne Johnson — vice-president, sales, Becton, Dickinson and Co., is retiring after 35 years with the firm. He will remain a B-D vice-president and policy consultant.

James A. Page, M.D.—has been appointed staff physician, medical department, Wyeth Laboratories. Until recently, he was with Aspro-Nicholas Ltd., English pharmaceutical firm, as assistant to the medical director.

Mario J. Cardone — has joined the chemical division, Borden Co., as head of the analytical research group at its Philadelphia research laboratory. He was formerly with Wyandotte Chemicals Corp.

J. Karl Taylor—has been promoted from warehouse and traffic supervisor to manager of the Dallas (Tex.) branch of Schering Corp. He succeeds John Westley who will manage Schering's new distribution branch in Atlanta, Ga.

Stanley L. Gray—has been named sales manager, Continental Hospital Industries, Inc. He was formerly in charge of eastern dealer sales for Continental.

NEW DISCOVERY

Saves Plumbing Bills
Cleans Instantly

CHICAGO — Nov. 1st — Homes, Sanitariums, Hospitals, Offices, including apartments are constantly having trouble with clogged-up pipes which proves expensive in Costly Plumbing Bills—

But now—using Water Impact and Air Pressure. here is a new unit called the **Plumber's Flushing Gun**, which cleans all lines up to 100 ft. It will open any number of bends in pipe. Yet anyone can operate this new gun, which triggers easily.

TOILETS, URINALS, SINKS, and FLOOR DRAINS clogged with paper, grease, rags, sand, and other debris can be cleared with one or more shots from the gun, **saving the owner, the Gun's price the first time it is used.** This new Flushing Gun may be used on any ½ to 6 inch waste pipe including Bathtubs, Floor Drains, Hot Water Pipes, House-to-Street Sewers, Septic Tanks, and Urinals. Obstructions melt away **INSTANTLY** when struck by the hammer like blow of this new unit.

This New Flushing Gun is offered on 30 Days Free **Trial. BUT MOST IMPORTANT IS THIS—What is this Tool worth in Costly Plumbing Bills Saved in your Home or Hospital. For your own good—Tear this Ad out now and write your name and address beside Ad for Free Booklet. No Agent will call—Obey that urge, mail now or write postcard. (Chicago Phone Kildare 5-1702) MILLER SEWER TOOLS. DEPT. HT-5. 4638 N. CENTRAL AVE., CHICAGO 30, ILLINOIS.**

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correct drying action—no waiting... allows trimming time, then hardens to full strength promptly

makes more comfortable, better-looking casts—lighter, thinner, smoother... yet much stronger than heavier, clumsier casts of old-style plaster

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costs less per cast than plain plaster!

Next time you need plaster bandages, specify modern, easier-to-use MELACAST in the new, plastic-lined, moisture-proof package . . . another outstanding development from Surgical Products Division.

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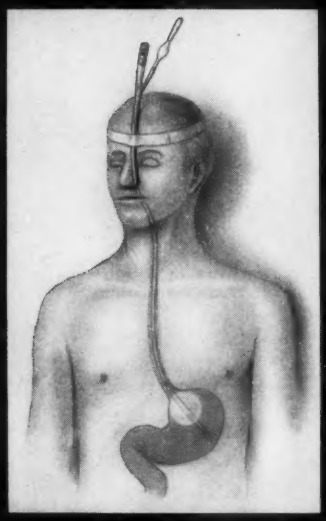
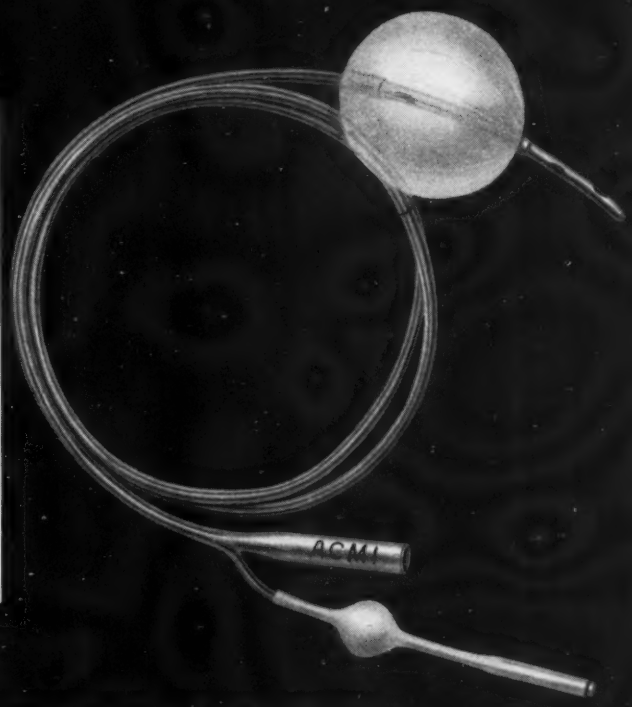
THE GILMAN GASTRIC TUBE

for

PREVENTION OF ASPIRATION OF GASTRIC CONTENTS DURING GENERAL ANESTHESIA*

Cat. No. 2760





Consult Your Dealer

The Gilman Tube is a double lumen gastric tube with inflatable balloon.
The tube is 16 Fr. in diameter and 122 cm. in length.
It has sufficient body to be passed easily through the nose into the stomach preoperatively.
The balloon should be inflated with 50 ml. of air.

FEATURES

- The use of the Gilman Tube reduces or eliminates the hazard of aspiration of gastric contents in the unconscious state.
- The Gilman Tube gives the physician a sense of security when he is introducing general anesthesia in a patient with a full stomach, and does not restrict him to the use of local or regional anesthesia.
- It permits the use of general anesthesia in cases of intestinal obstruction and marked gastric distention and in which peripheral circulatory collapse contraindicates the use of spinal anesthesia.

*New England Journal of Medicine 255:308-509 (September 13, 1956)

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This versatile threefold program provides greater standardization, economy and efficiency for all hospital departments participating in fluid balance therapy.

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For information about the benefits to your hospital of standardizing with the complete Mead Johnson line, see our Parenteral Products Representative or write to Parenteral Products, Mead Johnson, Evansville 21, Indiana.

71 Solutions and 34 types of equipment are available to your hospital from conveniently located Mead Johnson warehouses.

1957
research

1952
research

- Amigen ®
- Levugen ®
- Standard Electrolyte Solutions
- Dextrose Solutions
- Parenteral Infusion Equipment
- Blood Transfusion Equipment

- Amigen
- Levugen
- Homeolytes
- Pediatric Solutions & Equipment
- Gastrointestinal Replacement Solutions
- Standard Solutions
- Blood Transfusion Equipment
- Parenteral Infusion Equipment
- Amigen (high calorie) Solutions

1947
research

- Amigen Protein Solutions
- Parenteral Infusion Equipment
- Concentrated Electrolyte Solutions

1937
research

- Protein Hydrolysates
- Intravenous fat emulsions

MEAD JOHNSON
SYMBOL OF SERVICE IN MEDICINE

How to get your patient

from operating table to dinner table

In less time

Amigen·800

(Mead Johnson)

"Intravenous protein feeding when properly used, not only does not compete with oral feeding, it actually encourages and facilitates resumption of the normal method of eating temporarily interrupted by surgical or other disease."*

Expediting the return to normal oral diet, Amigen 800 may supply daily as much as . . .

. . . 2400 calories
. . . 112.5 grams of protein
. . . all essential electrolytes
. . . and with a minimum of excess fluid

Intravenous administration of Amigen 800 minimizes or prevents protein depletion and negative nitrogen balance when patients are unable to eat. Not infrequently, a few days of Amigen 800 therapy produces sufficient nutritional improvement so that oral feeding can be resumed earlier and normalized sooner.

For further information about Amigen 800 write to Parenteral Products, Mead Johnson, Evansville 21, Ind.

**Elman, R.: Protein Needs in Surgical Patients, J. Am. Dietetic Assn. 32:524 (June) 1956.*

MEAD JOHNSON

SYMBOL OF SERVICE IN MEDICINE

Personally Speaking

Eva Bianco—has been appointed chief pharmacist, The Staten Island (N.Y.) Hospital, where she has been assistant pharmacist for the past year.

Jay Blanchard—has become administrator, McCrary-Ross Hospital, Lake City, Ia., succeeding **Mrs. R. E. McCullough**, who has resigned.

Vernon Brammer—has been named administrator, Kaiser Foundation Hospital, San Francisco. He was formerly administrator, Kaiser Foundation Hospital, Vallejo, Calif.

Gwendolyn Braxton, R.N.—has been appointed assistant supervisor, Mercy-Douglass Hospital, Philadelphia.

Mrs. Mary Ann Burn, R.N.—has been appointed director, School of Nursing, Presbyterian-St. Luke's Hospital, Chicago. She was formerly a faculty member, Boston (Mass.) College School of Nursing. She succeeds **Sylvia Melby, R.N.**, who has retired.

Carroll E. Clary—has been appointed administrator, Hillside Hospital, San Diego, Calif. He is a past president, Pennsylvania Osteopathic Hospital Association.

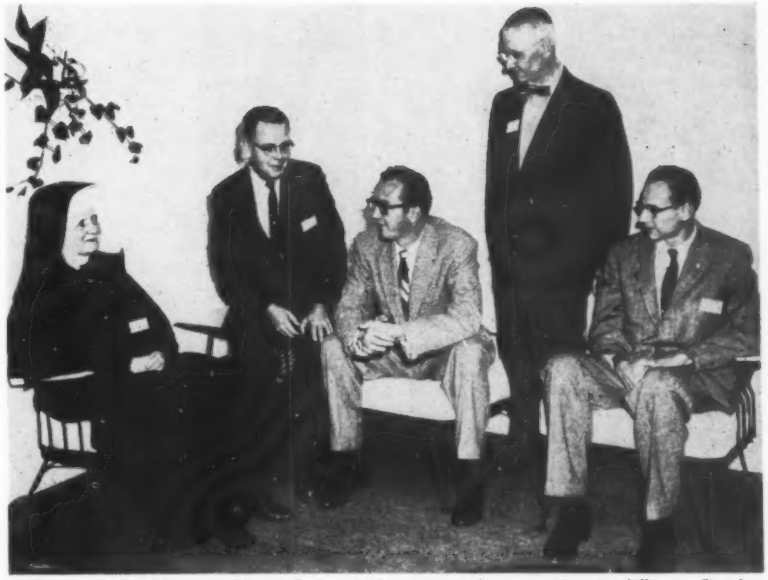
James B. Clemens—is now assistant executive director, Newington (Conn.) Home and Hospital For Crippled Children. He was formerly associated with Massachuetts General Hospital, Boston.

Walter V. Coburn—has been named administrator, Bethany Hospital, Kansas City, Kans., succeeding the late Bruce W. Dickson, Jr. Mr. Coburn was formerly administrator, Ransom Memorial Hospital, Ottawa, Kans.

Robert Cole—has been named resident administrator, Bradford (Pa.) Hospital, succeeding **Fred W. Schmid** who has resigned.

Robert G. Crist—has become assistant director, Hospital Association of Pennsylvania. He was formerly co-editor of the association's monthly newspaper and a public relations consultant.

Robert Crist



Officers of the Montana Hospital Association, pictured at meeting in Billings, October 8-10, are (l. to r.): Sister Ann Raymond, administrator, St. Vincent's Hospital, Billings, outgoing president; Robert D. Layng, administrative assistant, St. Vincent's Hospital, Billings, board member; Donald S. Showman, administrator, Kennedy Deaconess Hospital, Havre, secretary-treasurer; George F. Pendergraft, administrator, Glacier County Memorial Hospital, Cut Bank, president; Robert D. Howe, administrator, Deaconess Hospital, Billings, president-elect. Sister John Baptist, SCL, administrator, St. John's Hospital, Helena, vice-president, and William A. Guy, Billings, executive secretary, were absent when the picture was taken.

John R. Eckrich—has been appointed administrator, Lutheran Hospital of St. Louis, Mo.

Ward E. Edwards—assistant administrator, Middlesex Memorial Hospital, Middletown, Conn., has become assistant administrator, Lutheran Deaconess Home & Hospital, Minneapolis, Minn.

Archibald C. Eglin, Jr.—has assumed the post of comptroller, Jefferson Medical College and Hospital, Philadelphia, succeeding the late **George M. Ritchie.**

Vera B. Eidt—administrator and director of nursing, Trail-Tadanac Hospital, Trail, B. C., for over ten years, resigned September 1 to pursue postgraduate study at the University of Toronto School of Nursing.

Laura Eno, R.N.—formerly director, nursing service, Ryburn Memorial Hospital, Ottawa, Ill., has become director, nursing service, Blessing Hospital, Quincy, Ill., succeeding **Anne Anderson, R.N.**, who resigned.

Bernard Entman—has succeeded **Melvin Dray** as assistant executive director, Orthodox Jewish Home for the Aged. Mr. Dray has been appointed administrator, Jewish Home of the Northwest, St. Paul, Minn.

Fred K. Fish—has resigned as director, Lutheran Hospital of Brooklyn, N.Y., to become executive director, New York Polyclinic Medical School and Hospital.

Rodney E. Gannon—has been appointed business manager, St. Elizabeth Hospital, Yakima, Wash. Previously, he served as business manager, Samaritan Hospital, Moses Lake, Wash.

W. E. Guthrie—has resigned as administrator, Paradise Valley Sanitarium and Hospital, National City, Calif. He will be succeeded by **Rev. Melvin V. Jacobson.**

L. Stephen Hartford—has become superintendent, Newton (N.J.) Memorial Hospital, succeeding **Paul E. Widenor**, who resigned. Mr. Hartford was formerly assistant administrator, University of Texas Medical Branch Hospitals, Galveston, Tex.

Peter R. Haviland—has been named administrative assistant, Iowa Lutheran Hospital, Des Moines.

Robert James—has become administrative assistant, Saint Francis Memorial Hospital, San Francisco, succeeding **Alfred Muller, Jr.**

(Continued on next page)

Harrison Kehr—formerly assistant administrator, Phelps County Memorial Hospital, Rolla, Mo., is now administrator, Ray County Hospital, Richmond, Mo.

Dorothy Kinyoun, R.N.—has resigned from the staff of John Cochran Hospital, St. Louis, to become assistant director of nurses, Burlington (Ia.) Hospital School of Nursing.

Alvin Knauss—has resigned as administrator, Sarah D. Culbertson Memorial Hospital, Rushville, Ill. No successor has been named.

William J. Kramer—has become executive director, San Francisco Hospital Conference. He was formerly assistant director, Mount Zion Hospital, San Francisco.

Robert C. Krutz—has been appointed assistant administrator, Citizens General Hospital, New Kensington, Pa.

William C. Lightburn—has succeeded Charles M. Edwards as assistant administrator, Lincoln (Nebr.) General Hospital. Mr. Edwards has become administrator, Sedalia (Mo.) Memorial Hospital.

Edward J. Locke—has been appointed business manager, Marietta (O.) Memorial Hospital.

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All inquiries are strictly confidential.

John J. Lorentz, M.D.—has been appointed physician in charge, Boston Dispensary Rehabilitation Institute, and assistant professor, physical medicine and rehabilitation, Tufts University School of Medicine, both units of the New England Medical Center, Boston. Previously, Dr. Lorentz was assistant medical director, Bay State Medical Rehabilitation Clinic and department of physical medicine, Massachusetts General Hospital, Boston.

Malcolm D. MacCoun—has been named assistant administrator, St. Mary's Hospital, Grand Rapids, Mich. He was formerly associate director, Hackley Hospital, Muskegon, Mich.

Donald M. MacIntyre—has become administrator, Kingston (Ont.) General Hospital, succeeding **R. Fraser Armstrong.**

Mrs. Norrine Major, R.N.—has been appointed director of nursing, Western Pennsylvania Hospital, Pittsburgh. She was formerly director of nursing, Evanston (Ill.) Hospital.

Ruby Martin, R.N.—has been promoted from associate director to director, nursing service, Presbyterian-St. Luke's Hospital, Chicago.

Steve F. McCrimmon—has resigned as administrative director, Doctors' Hospital, Coral Gables, Fla., to become administrative director, Baptist Hospitals of Miami. He was installed as president, Florida Hospital Association, November 21.

Vera J. Meeker, R.N.—has become director of nursing service, Bridgeport (Conn.) Hospital. She was formerly director of nursing service, Presbyterian Hospital-Olmsted Memorial, Los Angeles.

John B. Messinger—has been appointed public relations director, Morton F. Plant Hospital, Clearwater, Fla.

Elizabeth A. Moser, R.N.—has been appointed director, department of nursing services, Oschner Foundation Hospital, New Orleans. She was formerly associated with the Institute of Research and Service, Nursing Education, at Teachers College of Columbia University, New York.

Mother Tharsilla—has become administrator, Our Lady of Perpetual Help Hospital, Santa Maria, Calif. She was formerly on the staff of a Havre, Mont. hospital.

Alfred Muller, Jr.—has become assistant administrator, General Hospital of Everett (Wash.). He was formerly administrative assistant, St. Francis Memorial Hospital, San Francisco.

Lois J. Naughton, R.N.—has become superintendent, Silverton (Ore.) General Hospital. She was formerly on the staff of State Hospital, Salem, Ore.

Gerald R. Noble—has become director, St. Francis Hospital, Cambridge, O., succeeding **Leonard Cook** who resigned.

Thelma E. O'Donnell—has been named superintendent, Sierra Madre (Calif.) Hospital.

Mrs. Betty Pedersen—has become administrator, Tombstone (Ariz.) General Hospital.

Mrs. Garnett L. Radin, R.N.—has been appointed assistant director, Shriners Hospital for Crippled Children, Lexington, Ky.

Myrl L. Ray—formerly administrator, Cedar Valley Hospital, Charles City, Ia., is now administrator, John McDonald Memorial Hospital, Monticello, Ia.

William T. Robinson—has been appointed assistant director, Hospital Association of New York State. He was formerly assistant secretary, Council on Association Services, American Hospital Association.

Ed Schopp—has become business manager, McAuley Hospital, North Bend, Ore.

William P. Schweickert—has become administrator, Community Hospital, Falls City, Neb., succeeding **Lt. Col. Gary Bricker.** Mr. Schweickert was formerly director of the laboratory, VA Hospital, Dwight, Ill.

George A. Seamands—is now administrator, Wayne County Hospital, Humeston, Ia., succeeding **R. T. White.**

Jesse C. Simonds, Jr.—assistant administrator, Morrell Memorial Hospital, Lakeland, Fla., has been appointed assistant administrator, South Florida Baptist Hospital, Plant City, Fla. He succeeds **Alvin Goldberg** who has entered Georgia State College, Atlanta.

Sister Bernard Mary—administrator, St. Francis Hospital, Hartford, Conn., has turned over her duties as superior to **Sister Mary Annunziata.**

Sister M. Christine—treasurer, St. Francis Hospital, Lynwood, Calif., has assumed the post of administrator, succeeding **Mother M. Macaria,** superior-administrator. **Mother Noella** will become superior.

Sister Frieda Payne—has become administrator, St. Catherine of Sienna Hospital, McCook, Nebr., succeeding **Sister Mary Jane Fitzgibbons** who has been transferred to St. John Hospital, Spalding, Nebr.

Sheridan C. Snider—has been appointed director, East Orange (N.J.) General Hospital, succeeding the late Edgar C. Hayhow, Ph.D. Mr. Snider was formerly assistant director at the hospital. That position is held by **Forrest A. Brewer.**

Harold L. Slater—has been named administrator, John Burns Memorial Hospital, Belle Fourche, S.D., succeeding **Herbert Kempf,** who resigned. Mr. Slater was formerly administrator, Ogallala (Neb.) Community Hospital.

J. McDonald Smith—has become director, public relations, St. John's General Hospital, Pittsburgh, Pa. A former admiral, he has been engaged in public relations in the San Francisco area since his retirement from the Navy.

Wesley D. Sprague—secretary, New England Hospital Assembly, and former administrator, Brockton (Conn.) Hospital, has been named associate director, New England Deaconess Hospital, Boston.

Mrs. Clara M. Steiner—has resigned as administrator, Murphy Medical Center, Warsaw, Ind. She was formerly administrator, McDonald Hospital, Warsaw.

Truman Yates—has resigned as assistant administrator, Good Samaritan Hospital, Phoenix, Ariz. No successor has been named.

VA Appointments

Thomas L. Auth, M.D.—former chief, neurology service, VA Hospital, Washington, D.C., has succeeded **Benedict Nagler, M.D.,** as chief, neurology division, VA Central Office, Washington, D.C.

Robert S. Cohen, M.D.—formerly with VA Hospital, Birmingham, Ala., has become chief, Medical Service, VA Hospital, Poplar Bluff, Mo.

Willy Oppler, M.D. — has been appointed director, professional services, VA Hospital, Jefferson Barracks, Mo. He formerly held a similar position at VA Hospital, Perry Point, Md.

Paul M. Schmoll—has been appointed manager, VA Hospital, Whipple, Ariz. He was formerly assistant manager, VA Hospital, Fargo, N.D. He succeeds **Thomas O. Lake, M.D.,** who retired.

VA Nursing Appointments

John Adams—has been assigned nursing education and training specialist, VA Central Office, Washington, D.C. Previously he was assistant chief, nursing education, VA Hospital, Iowa City, Ia.

Irene Haarstick—has become chief, nursing service, VA Hospital, Northport, N.Y. She formerly held a similar position at VA Hospital, Gulfport, Miss.

Helen Hickey—is assistant chief, nursing service, VA Hospital, Beckley, W. Va. Prior to transfer she was a supervisor, VA Hospital, Hines, Ill.

Earl Kepart—has become assistant chief, nursing education, VA Hospital, Columbia, S.C. He was formerly an instructor, VA Hospital, Richmond, Va.

Mary McKinnon—has become chief, nursing service, VA Hospital, Grand Junction, Colo. Prior to transfer she was associated with VA Central Office Nursing Service, Washington, D.C.

Ruth Mershimer—has become assistant chief, nursing service, VA Hospital, Butler, Pa. Formerly she was a supervisor, VA Hospital, Martinsburg, W. Va.

Moveline Morgan—has been appointed chief, nursing service, VA Hospital, Gulfport Division, Biloxi, Miss. She previously held a similar post at VA Hospital, Ft. Lyon, Colo.

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NURSE ANESTHETIST: (a) Middle West. To work directly for chief anesthesiologist in 150-bed hospital. $500. (b) South. 250-bed hospital. M.D. anesthesiologist in charge. 5 nurse anesthetists in dept. To $650. (c) Northwest. 200-bed hospital. 2 nurse anesthetists and 1 anesthesiologist in dept. $500. (d) West. Also act as administrator in 25-bed hospital. Previous administrative exp. not necessary. Man or woman. $600-$700. (e) South. New 100-bed hospital. 2 in dept. $650.

SOCIAL SERVICE: (a) Pacific Coast. Assistant Director-Medical. $6,000. (b) East. Chief Psychiatric. Minimum 5 years' exp. $7,800. (c) East. Medical. 200-bed hospital. Easily accessible to N. Y. City. $5,000 minimum. (d) South. Psychiatric. Large mental hospital. $6,000 plus complete maintenance for family.

NOTE: We can secure for you the position you want in the hospital field, in the locality you prefer. Write for an application—a postcard will do. All negotiations strictly confidential.

Marion Rich — has been appointed chief, nursing service, VA Hospital, Huntington, W. Va. She was formerly assistant chief, nursing service, VA Hospital, Providence, R.I.

DEATHS

Eugene B. Ferris, Jr., M.D.—52, medical director and former vice-president, died recently in New York City. Previously he had been professor and chairman, department of medicine, Emory University School of Medicine, Atlanta.

Jacob W. Frank, M.D.—84, an early leader in radiology, died October 3. A diplomate, American Board of Radiology, he was the first professor of radiology, Hahnemann Medical College, former head, the college's radiology department, and author of many papers in his field.

Mary Ann Garvey, R.N.—55, director, nursing service, Athens-Limestone Hospital, Athens, Ala., died September 16.

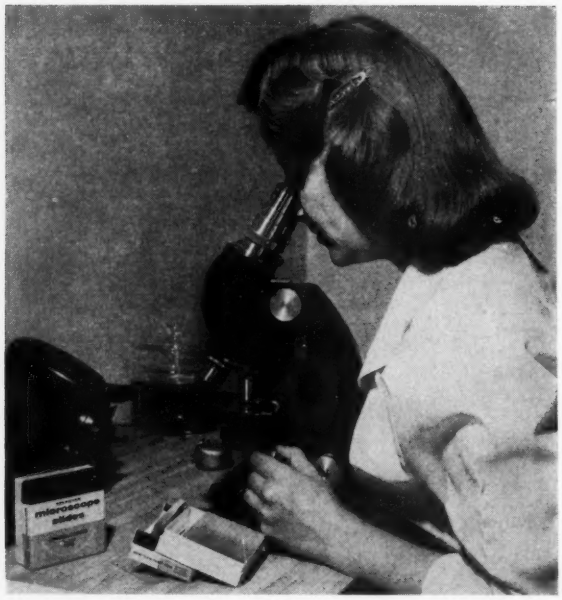
(Continued on page 125)

BUYER'S GUIDE

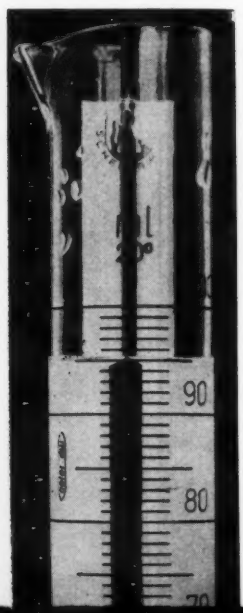
For further information on any of the products, please check the Buyer's Guide number on the reply card opposite page 128.

Evelyn Sebastian
Buyer's Guide Editor

100. Microscope slide box



New, hinged-top box permits precleaned microscope slides to be slipped in or out without fumbling or fingerprinting their surfaces. Each box fully lined with coated, dust-free paper. When opened and folded back, it provides shelf for used or unused slides. Glasco Products Co.



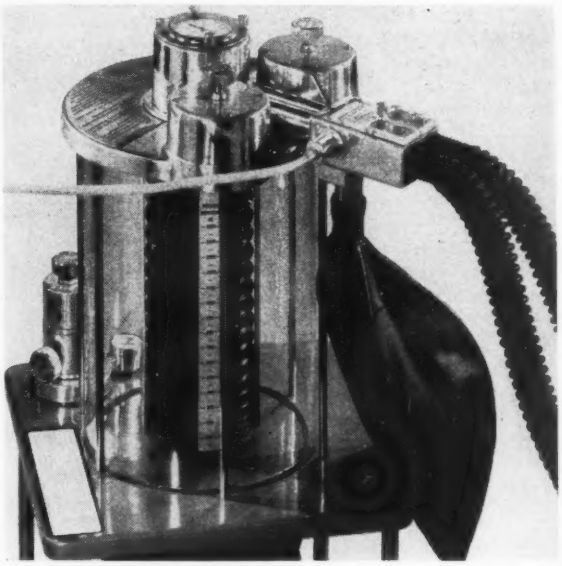
101. Graduated cylinder

Wide, blue vertical lines, well-known feature of Shellbach graduations, are now available on new line of graduated cylinders. High visibility of banding allows accurate lining up of meniscus against graduations. Polished surface creates undistorted magnification. Hexagonal base for stability. Kern Laboratory Supply Co.

102. Hospital bed

Adjusto-Hite, new hospital bed, has adjustment crank that automatically returns bed to level position from any therapeutic position without further adjustments by operator. Crank folds compactly into handle casing at foot of bed. Twin telescoped legs provide easy action in raising and lowering, even when bed is occupied by a heavy patient. Harris Hub Co., Inc.

103. Nonrebreathing head



Nonrebreathing head, made to fit any Jefferson ventilator, makes possible mechanical ventilation with intermittent negative and positive pressure during nonrebreathing anesthesia technics. Head is shown fitted to new GH-3 Volume-Indicator model which has bellows-type internal rebreathing reservoir and conversion chart for precise estimate of tidal exchange under various gas flows and rates of respirations. Air-Shields, Inc.

104. Name plate

New, numbered aluminum name plate (No. 1000 series) with grooved channel for accommodating name card is designed to identify hospital rooms and occupants. Any sequence of numbers or letters available. Characters recessed for permanency and finished in a contrasting enamel. Choice of four anodized colors— black, bronze, brass, and natural aluminum. J-C Products Corp.

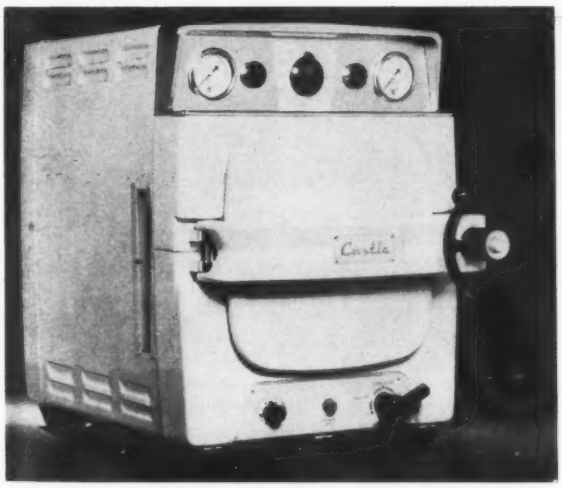
105. Surgeons' gloves

New "Surgiderm" gloves are said to reduce hand fatigue by requiring 25 to 30% less energy to flex fingers and hands. The glove combines softness and comfort with strength and aging qualities, according to manufacturer. Sundries Division, B. F. Goodrich Industrial Products Co.

106. Plastic wall coating

Zolatone, multi-flecked, spray-on plastic coating with camouflaging properties, cuts cost of materials and reduces number of man hours necessary to maintain painted surfaces, manufacturer says. Nonstatic qualities make it stain-resistant. Cleaned with any household cleaner or paint-thinner. Durable. Because it has little odor, it can be applied even when patients are in rooms. Zolatone Process, Inc.

107. Portable autoclave

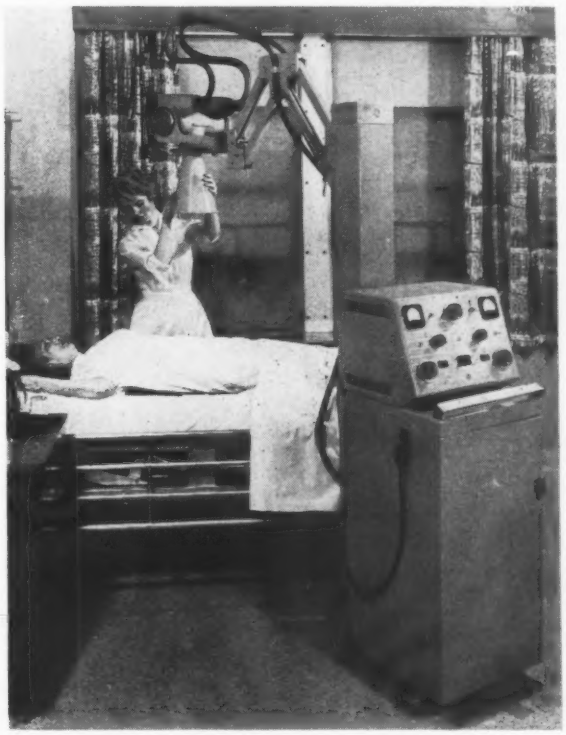


Castle 999, portable autoclave, has no protruding valves, piping, tanks, or spigots. Single-handle dial control governs sterilizing cycle. Fast initial steam build-up. Double-shell construction provides standby steam reserve; variable pressure regulator provides optimum sterilizing time-temperature conditions. The 9" x 16" internal chamber holds up to 1,017 cubic inches. Unit finished in heat-resistant, oven-baked enamel. In jade, coral, silvertone. Wilmot Castle Co.

108. Technicon analyzer

Technicon Autoanalyzer is accurate, reliable, speedy in determination of urea and sugar in blood, calcium in serum, manufacturer says. No measuring of agents and reagents necessary. Analyzer runs continuously at 40 determinations an hour. Reactions are permanently recorded and charted as they occur. Autoanalyzer estimated to produce same results in one hour technologist time as are obtained in 16 hours when manual methods are used. Technicon Co.

109. Bedside radiography



Mobile "200" x-ray unit has more than double the power of conventional x-ray equipment, according to manufacturer. Operating at 200 milliamperes, unit stops patient motion, permitting shorter exposure time. Features include rotating-target x-ray tube, electronic timer for greater precision. Accordion-like extension arm makes it possible to extend tube over bedside for 20". Suitable for cross-table radiography, upright chest x-rays, and other examinations requiring positions difficult to attain with floor-mounted stands. General Electric.

110. Sta-Cel

Sta-Cel "S" consists of liquid suspension of preserved sheep erythrocytes intended to replace fresh sheep cells in detection of heterophile antibody with either rapid plate or tube method. Eliminates disadvantages of using fresh sheep red cells, such as washing of cells, maintenance of fresh supply, and inactivation of serum prior to the test. Stable for at least one year. Scientific Products, American Hospital Supply Corp.

BUYER'S GUIDE

111. Heat lamps

Golden Glow infrared heat lamps are safe and easy to operate. Flat reflector plate in hood gives uniform, comfortable treatment. Other features: replaceable chromalox all-metal burners that lock in place, special bushing in telescoping shaft to prevent sudden drop, and heavy cast-iron base and safety stop to guard against tipping. Large hand-fitting knobs and levers provide easy operation. All adjustments made from behind lamp, away from patient. Lamps come in 500, 750, and 1,000-watt ratings. Birtcher Corp.

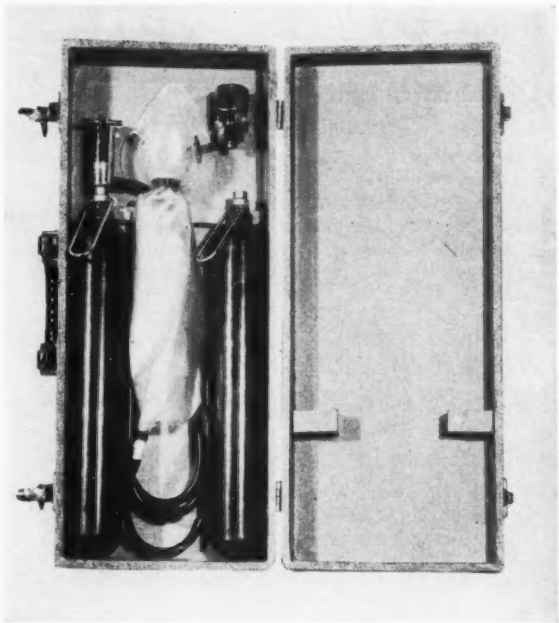
112. Shower-shield & toe-cap

"Shower-Shield," water-tight, disposable plastic boot, can be slipped on over arm or leg cast to enable patient to bathe without soaking cast. Elastic band holds shield in place. "Toe-Cap," slip-on half-sock, keeps toes clean and warm in cold weather. Orthopedic Frame Co.

113. X-ray film badge

Gardray film badges warn personnel in x-ray, radioisotope laboratories of over-exposure. Each badge has special two-film packet, calibrated penetrameter which estimates quantity and quality of radiation. Date when wearer starts using badge, control number, and name or initials are imprinted on film emulsion to avoid errors. Picker X-Ray Corp.

114. Oxygen inhalator

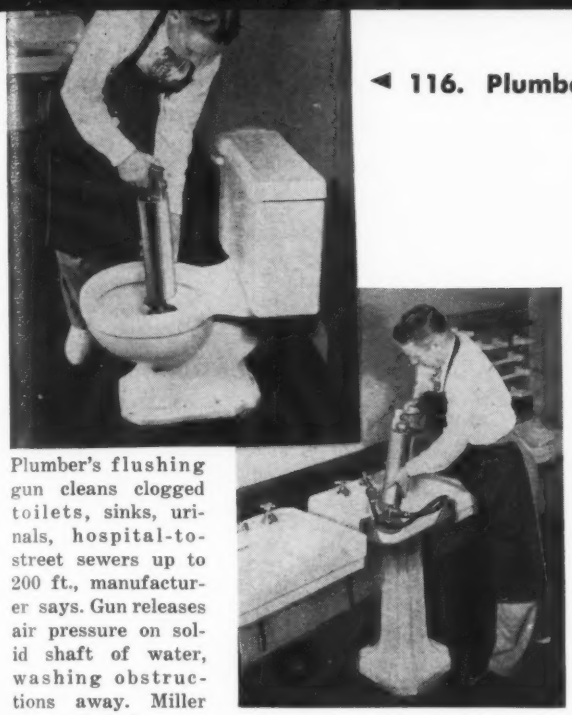


Light, portable, compact Davis oxygen inhalator permits oxygen to be administered instantly, anywhere, for general first-aid use. Two easy-to-refill oxygen cylinders last 15 minutes each when oxygen is diluted 50 percent with air. Adjustable rate of flow to match patient's breathing. Underwriters Laboratories-approved pressure regulator. Davis Emergency Equipment Co., Inc.

115. Cough syrup

New Conar Troche, over-the-counter cough preparation, makes mint-flavored liquid Conar available in solid form. Principal ingredient is noscapine (formerly narcotine) which checks cough without narcotic depression, according to manufacturer. Green-tinted troche and syrup also contain antihistamine to combat allergy coughs. Each carton contains 15 vials. S. E. Massengill Co.

◄ 116. Plumber's flushing gun



Plumber's flushing gun cleans clogged toilets, sinks, urinals, hospital-to-street sewers up to 200 ft., manufacturer says. Gun releases air pressure on solid shaft of water, washing obstructions away. Miller Sewer Rod Co.

117. Surgical dressing

Aeoroplast ® plastic protective surgical dressing is now available in two additional sizes, with a yellow tint added for visual indication of the area being dressed and the amount being applied. The 3-oz. size is suggested for the physician's office, surgical dressing carts, and for patient use. Large 12-oz. size is economical for O.R. use. The original, clear Aeroplast is still available in 6-oz. container. Aeroplast Corp.

118. Plastic tubing connectors

Six new connectors, for use with standard sizes of tubing, have been added to the line of molded nylon connectors. Straight connectors are now available in ¼", $\frac{5}{16}$", and ⅜" sizes. Sims irrigation nozzle is now available in one-piece design. Quick tubing connector comprises male and female parts, each with a winged flange. One part can be fitted to tubing, the other to equipment where action is intermittent. Easy to connect or disconnect. Also available in ¼", $\frac{5}{16}$", and ⅜" tubing sizes. All connectors are transparent, shatterproof, safe to use. Pharmaseal Laboratories.

▼ 119. Form flow register

Model 7000, light-weight, portable form flow register with pinfed feature, gives forms control, alignment, feeding performance. Register easily handles up to 6-part sets, even including forms stapled together. Accessible storage compartment holds generous supply of multi-copy forms. In three sizes: 5¾" x 8½"; 5¾" x 6½"; $4\frac{5}{8}$" x 6½". Choice of six colors. Standard Register Co.

120. pH meter

Pocket-sized, light-weight pH meter gives quick, accurate pH measurement in laboratory, plant, or field. Features combination glass-reference electrode with 36" lead, which may also be used while still clamped to instrument's side, allowing operator free hand for notations. Measurements of 2 to 12 pH possible with readability of 0.1 pH. Lower values can be measured by simple adjustment. Power supplied by 6 standard-type batteries. Shoulder-type carrying case available as accessory. Scientific Instruments Division, Beckman Instruments, Inc.

BUYER'S GUIDE

Continued

121. Micro-balance

Electrobalance, portable microbalance, weighs small samples ranging from 0-5 mg. to 0-50 mg. accurately in a few seconds, manufacturer says. Instrument operates by electric measurement of torque. Reads directly in micrograms. Smaller than portable typewriter. Manufactured by Cahn Instrument Co. Available through Central Scientific Co.

122. Stain remover

ExGo liquid stain remover removes stains of x-ray, photodeveloper, medicines with silver nitrate base from clothes, linens. Applied to stain and flushed out with water. Won't harm or discolor fabrics. A. L. Wilson Chemical Co.

123. Plastic basket

Lustro - Ware one - piece, rectangular wastebasket of polyethylene is made to withstand abuse. Can't dent, chip, rust, or stain. Molded-in feet minimizes noise. Handle rim top permits safe, easy pickup from any side. Columbus Plastic Products, Inc.

124. Kiddie oxygen mask

Kiddie Space disposable oxygen mask, made especially for children 5 years and under, is designed to dispel child's fear in use of oxygen. Shows tiny spacemen in full salute standing beside space jets. Mask also used for induction of anesthesia. Light-weight, sanitary. Child can move his head or carry on conversation. Ohio Chemical & Surgical Equipment Co., Division of Air Reduction Co., Inc.

125. Detergent cream

Hexa-Germ, antiseptic skin detergent, simplifies and shortens time required for preoperative surgical hand washing as well as preparation of patients, according to manufacturer. Detergent contains 3% Hexachlorophene, lanolin, and petrolatum. Carbopol 934, a water-soluble resin, is added to preparation for smooth, creamy consistency. Huntington Laboratories.

126. Disposable cup

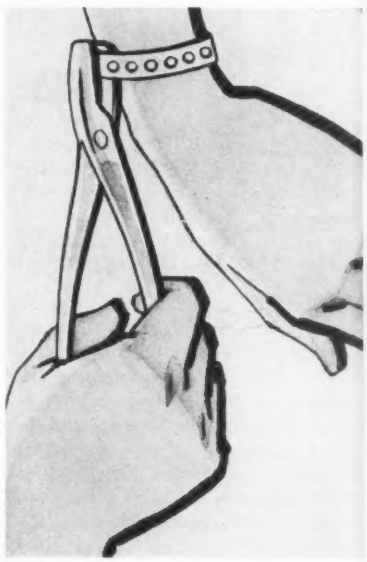
Disposable all-plastic cup holds 7 oz. of liquid. Folding handle locks in slip-proof grooves. Heat-resistant polystyrene suitable for hot beverages and soup. No heat transmitted to handle or lip of cup. Federal Tool Corp.

127. Shock therapy bed

Manually operated Hilow shock therapy bed for use in psychiatric departments and mental hospitals can be raised or lowered to desired therapeutic positions. Features are: flat, fabric spring for shock treatments; safety sides permanently attached to bed; low, aluminum head and foot ends; wrap-around rubber bumpers and 4"-deep foam rubber mattress covered with nylon cover and impregnated with neoprene rubber. Hill-Rom Co., Inc.

128. Identification bracelet

Shur-Lok identification bracelets of tough, low-pressure polyethylene are soft and comfortable, yet won't weaken, stretch or break, manufacturer says. Rosettes which fasten bracelet to name plate have special locking tip. Bracelet can be assembled, fitted, and applied with Shur-Lok applicator. Presco Co.



129. Electronic control system

Hospital-Master, electronic control system, enables surgeon to request temperature adjustments while in the O.R. and gives supervisory nurse complete control over heating and air conditioning in specialized hospital areas. Intercom between surgery and nurse is integrated with 5-foot-long control panel, equipped with pushbuttons, lights, knobs and a telephone. Surgeon merely steps on foot pedal beneath surgery table which rings a bell on telephone. Sensitive microphone above surgery table picks up surgeon's voice. Nurse pushes a button, gets temperature reading from an indicator, and resets to desired temperature by turning a calibrated knob. Minneapolis-Honeywell Regulator Co.

130. "Talking books"

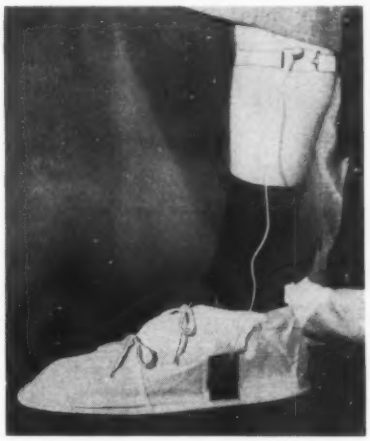
Full-length books and novels, as well as stories, recorded on 12" 16-⅔ rpm phonograph discs, provide therapeutic as well as recreational value to nonambulatory patients. New adapter which converts 33⅓ rpm turntable speed to 16⅔ rpm., and "sonograph," which is equipped with earphones or pillow speaker, for silent or small group listening, are optional. Books cover wide range of interest. Playing time per disc, about 2 hrs. Offered on subscription-service plan. Libraphone, Inc.

131. Reminder-timer

Pocket-size reminder timer which clips onto uniforms can be preset to buzz at certain intervals for 5 minutes up to 4 hrs. Can be used to time diathermy, ultrasonic, infrared, or ultraviolet treatments. Knob winds Swiss jeweled movement and alarm simultaneously. Arista Surgical Co.

132. Conductive bootie

Spark-proof, ankle-height conductive bootie assures drainage of static electricity from skin to conductive floor. Positive contact maintained by snap-on elastic garter assembly with contact plate. Worn over ordinary shoes. Easily laundered. For men and women. In four sizes. Walter G. Legge Co. Inc.



133. Food conveyor

Touch-n-Go Foodveyor, self-powered, variable-capacity food conveyor, cuts labor cost, minimizes accident hazards, and speeds up meal distribution, says manufacturer. Operator manuevers the 600-lb. unit forward or backward by pushing a control button at end of steering handle. Manual operation also possible by depressing foot lever which lowers an extra wheel. Foodveyor remains in motion only when button is pressed. Powered by 12-volt automotive battery. Has capacity of from 18-24 meals, and separate, insulated heating and refrigeration compartments. S. Blickman, Inc.

134. Postoperative sponges

Sterile, machine-wrapped, cotton-filled postoperative sponges, ready for patient use, result in a saving of approximately 25 percent, manufacturer says. Each package has two 4" x 4" Topper sponges. Johnson & Johnson.

135. Dextol

Dextol solution, flavored with lime-lemon extract, ends patient's objection to taste, saves technologist's time preparing "cover-up" flavoring. Accurate and compatible with standard glucose tolerance procedures, each bottle contains 200 ml. of Dextol with 100 G. of U.S.P. glucose, is graduated for easy calculation. Scientific Products Division, American Hospital Supply Corp.

136. Molded products

Merco breast pump and Merco nipple shield are designed to withstand repeated sterilization. Rubber bulb of breast pump fits snugly over glass neck and is guaranteed leak-proof. Mercer Glass Works, Inc.

NEW LITERATURE

140. Worry-warts

"Worry-Go-Round," semi-humorous booklet, amusingly illustrated with cartoons, gives a clue to the understanding of everyday tensions. Connecticut Mutual Life Insurance Co.

141. Revised catalog

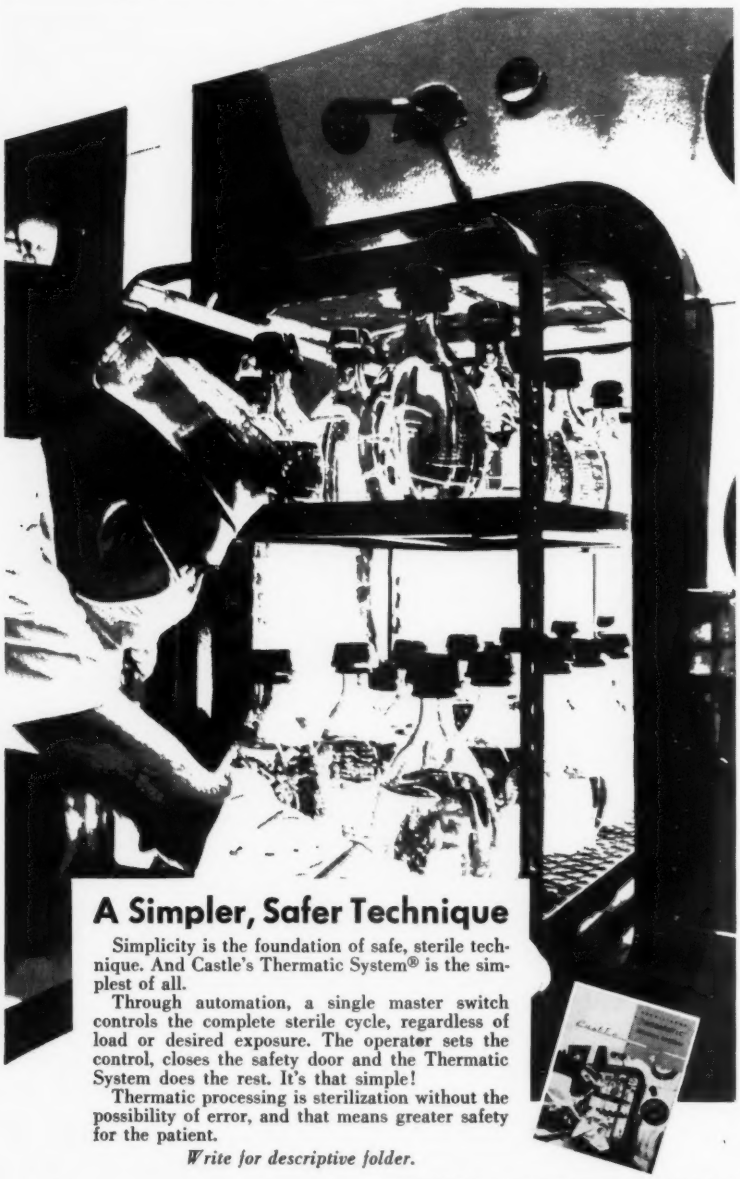
Chart-Pak's 1957 catalog, revised and enlarged to 24 pages, includes new products added to line of pressure-sensitive printed tapes, templates, charting materials. Chart-Pak, Inc.

142. Filing units

New brochure outlines advantages of Verti-File, open shelf filing unit. Booklet includes color specification and range of available optional accessories. Deluxe Metal Furniture Co.

143. Cost reduction

Evaluation of factors in cost reduction, as well as suggestions for specific steps to be taken are discussed in "Short Cuts to Greater Profits," new booklet put out by Equipto, Division of Aurora Equipment Co.



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144. For expectant parents

"The ABC's of Prenatal Care," 40-page booklet, provides practical answers to the questions most commonly asked by first-time parents-to-be. Edited by a specialist in obstetrics and gynecology, booklet is designed to dispel hearsay information and half-truths connected with child-bearing. Heinz Baby Foods.

145. Guide to ultracentrifugation

The functions of analytical rotors and their cells and accessories, working tools of analytical ultracentrifugation, are described in detail in illustrated catalogue, Form SBE-20. The Spinco Division, Beckman Instruments Co.

146. Autrometer

Operating principles and application of improved Norelco Autrometer, automatic indexing x-ray spectrograph, are explained in 8-page illustrated booklet. Instruments Division, Philips Electronics, Inc.

147. Recreational guide

Second edition of AGBOR, "A Guide to Books on Recreation," includes more than 850 titles from 125 publishers. Special sections include recreation for the ill and handicapped, listing hobbies, games, and puzzles for entertaining the bed-ridden. A section on administration and planning is also included. National Recreation Association.

148. Specialties and sundries

Recently released catalog No. 9 has 144 pages and over 1,250 illustrations of specialties and sundries useful to the hospital and surgical trade. Many new items have been added to previous catalog. Graham-Field Surgical Co., Inc.

AHA Convention Activates Interest In New Items

The technical exhibits excited unusual interest during the recent annual convention of the American Hospital Association. Last month TOPICS carried write-ups on some of the new products in its special insert. This month these reviews are continued. For more information, circle the Buyer's Guide card appearing opposite page 128.

ALL PHOTOS BY TOPICS

Below: Sterile Rib-Back blade of Bard-Parker Co., Inc., is the subject of conversation between Don Kuykendall, sales representative, and Marjorie Eberhardt, purchasing agent, Elyria (O.) Memorial Hospital. Also displayed was the Rack-Pack which provides extra blade protection. C-150.

Below: Mrs. F. G. Bruesch and Mr. Bruesch, administrative assistant, Harper Hospital, Detroit, ask Norman Power (r.), ASR Products Corp. representative, about Steri-Sharps, the sterile, stainless steel surgical blades. Heat-sterilized, the blades eliminate preparation damage and dulling by chemical solutions. C-151.

Above: William H. Pigg, administrator, Galveston Memorial Hospital, La Marque, Tex., looks at the self-closing ropeless laundry bag for use in conveying soiled linen from the floor to the laundry. Peggy BeVier, sales manager, Self Closing Ropeless Bag Co., demonstrates the product. C-152.

Above: Edith Gertner, auxiliary member, Mt. Sinai Hospital, Miami Beach, Fla., gets additional information from Abe Soontup, J. A. Deknatel & Son, Inc., concerning Plastic Pak, the hermetically sealed sterile suture pack. C-153.

AHA Items

Activate Interest

Above: Reuben H. Graham (l.), purchasing agent, North Carolina Baptist Hospital, Winston-Salem, N.C., pauses with Richards Mfg. Co. representative to look at new stainless steel instrument boxes which can be autoclaved. C-154.

Right: Robert Kelly (l.), Methodist Hospital, Brooklyn, N.Y., listens to Fred Harris, Jr., explain features of new design in mopping outfit of White Mop Wringer Co. C-157.

Left: Bernard Lachner (r.), assistant director, Ohio Tuberculosis Hospital, Columbus, looks at bath seat with three-inch suction cups that grip bottom of tub in the Bollen Products Co. booth. R. Bollen explains seat cannot slip or tilt. C-155.

Above: An Ident-A-Band for positive on-the-patient identification is being applied to Peter Terenzio, executive vice-president, Roosevelt Hospital, New York City, by Debora Milly, Franklin C. Hollister Co. Lucille Adams (r.), Hollister, looks on. C-158.

Below: W. W. Fischer, representing Colson Corp., shows Mrs. Le Roy Bufford, Springfield State Hospital, Skyville, Md., folding wheel chair with reclining back. The chair can be folded quickly to a slim 11" thickness for storage. C-156.

Above: Kingsley Meyer (l.) tells Ligaya Villaneuva, student, St. Mary's Hospital, Rochester, Minn., about Davol Rubber Co.'s plastic nursing bottle, while Joseph W. Chestnut explains details of the Davol special formula service plan to Florencia F. Rafanan, nurse anesthetist, V. Luna General Hospital, Quezon City, Philippines. C-159.

Below: Alcotabs, the new, advanced detergent in tablet form that cleans pipettes, attracts the attention of Russell H. Miller (r.), associate director, University of Kansas Medical Center, Kansas City, Kans., and Robert A. Molgren, administrator, St. Luke's Hospital, Kansas City, Mo. Edward P. Fenlon (l.), sales manager, Alconox Inc., tells them how foreign matter can be removed. C-161.

Below: Joseph E. Stocks (r.), supervisor, medical laboratory, West Jersey Hospital, Camden, N.J., inquires about Alevaire, aqueous solution of superinone and glycerin, for aerosol therapy, from R. H. Rahmeyer, Winthrop Laboratories sales manager. C-162.

Additional meeting reports and pictures from the AHA Convention held recently in Atlantic City can be found on pages 17-20 of this issue of TOPICS.

Above: Arthur Carvolth, administrator, St. Luke Hospital, Ft. Thomas, Ky., examines the arm lateral fracture unit in the Gilbert Hyde Chick Co. booth. George Bulger (r.) points out that set will fit bed at various angles. Traction unit allows any type of arm traction from any position, and follows the patient as he is raised or lowered. C-160.

Above: Henry Young, sales representative, Connecticut Bandage Mills, Inc., shows Sister Mary Denis, OB supervisor, Mercy Hospital, Baltimore, Md., latest method of using Elasticfoam, foam rubber, non-slip pressure bandage. C-164.

Activate Interest

Above: Capt. Edmund F. Lentz, M.C., U.S.N.R. headquarters, third district, New York City, gathers information from William Kiley on Amphyl and other Lehn and Fink Products Corp. disinfectants. C-165.

Above: The stainless steel recovery room stretcher in the Gendron Wheel Co. booth stopped Anthony Maranga, administrative assistant, St. Barnabas Hospital, New York City, and Judith Carlson, nurse, Northwestern Hospital, Minneapolis. Bob Diemer (l.) of Gendron tells them how the stretcher can be moved with extreme ease. C-166.

Right: Mrs. Harold Coston and Mr. Coston, administrator, Cambridge (Md.) Hospital, stop in at the E. F. Hauserman Co. booth, where Robert Collier Page (r.), consultant, shows them Hospital Industries Association award presented to Hauserman for best display in booth over 200 feet. Exhibit featured applications of Hauserman steel medical walls, in a variety of colors, for rooms, offices and reception areas. C-167.

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Above: Twelve shades of color-coded caps for needle identification are featured in the Sterilon Corp. booth. Harry Stewart explains them to Sister Mary Dorothy, supervisor, and Sister Mary Damian, instructor, both of Mercy Hospital, Baltimore. The reusable nylon containers keep needles sterile, easy to sort and ready for instant use. C-168.

Above: Ralph Wilgarde (l.), administrative assistant, Jefferson Hospital, Philadelphia, stops at the Mallinckrodt Chemical Works display to chat with D. T. Carlson about new packaging of Indicating Soda Lime for carbon dioxide absorption, and Thixokon, a new medium for urethrography. C-169.

Below: Colin Campbell McLean, Hospital Furniture, Inc., pets rabbit, feature of booth's display of furniture coordinated with interior design, planning, furnishing and color styling of hospitals. C-170.

Above: Frank G. Bruesch, administrative assistant, Harper Hospital, Detroit, tests lightweight coffee cart, constructed of aircraft aluminum, with Mrs. J. S. Ferry, hospital representative, Bucks County Enterprises, Inc. C-172.

Right: S. J. Mozolak, purchasing agent, Clara Maass Memorial Hospital, Newark, N. J., chats with Jay Dorsak, Gordon Armstrong Co., Inc., about the Hand-Hole baby incubator with the 40 percent oxygen limiting nebulizer, and 40 percent oxygen limiting valve. C-171.

Above: John Gabel (l.), manager, hospital division, Wilmot Castle Co., explains how Sterox-O-Matic gas sterilizer permits rapid processing of heat and moisture-sensitive supplies to Lee Stillwell (center), superintendent, Chillicothe (O.) Municipal Hospital, and Capt. Ira Parkman, USAF (ret.), Medical Service Corps, East Meadow, N.J. C-173.

Left: S. Z. Charka, Hill-Rom Co., Inc. representative, demonstrates the all-electric Hi-Low bed with push-button controls. Power is supplied by a 1/12 hp motor. A safety lock system makes it possible to set the bed in any one position. Theodore F. Childs (l.), president, Lenox Hill Hospital, New York City, watches the demonstration. C-174.

FREE YOUR NURSES FOR NURSING...

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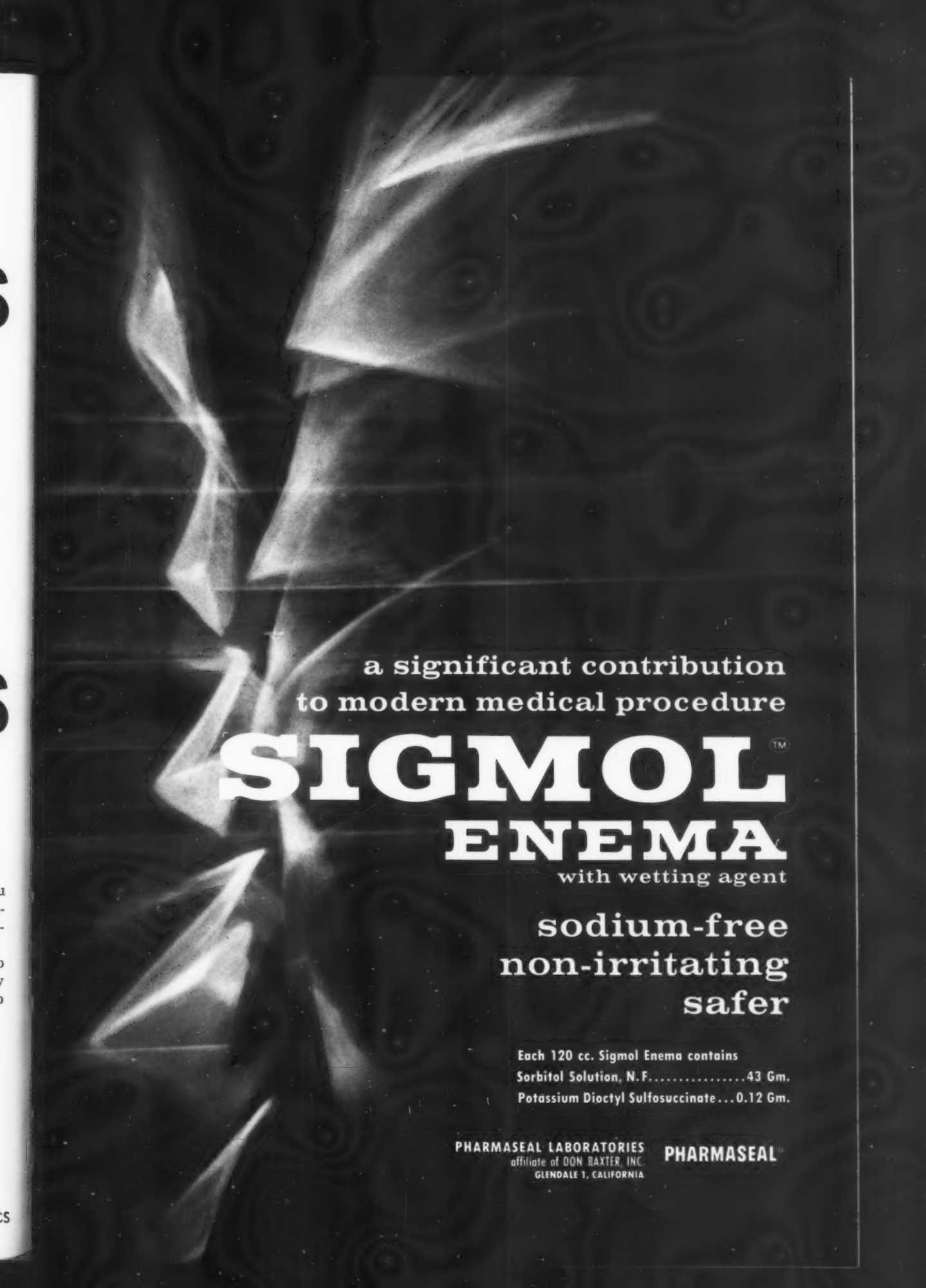
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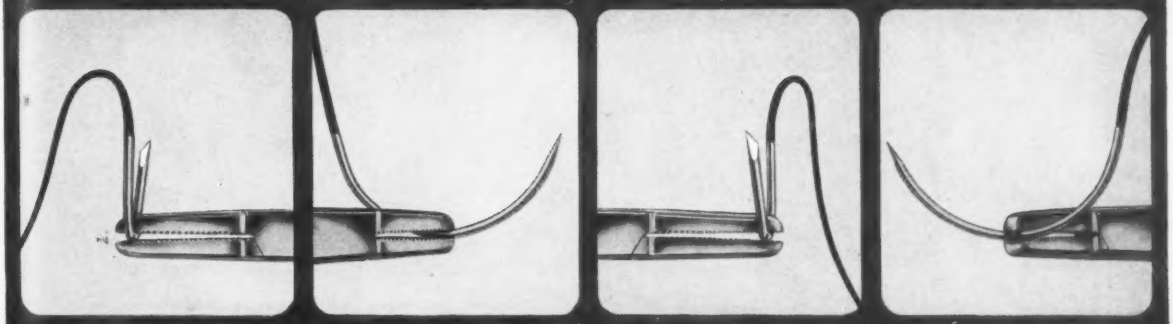

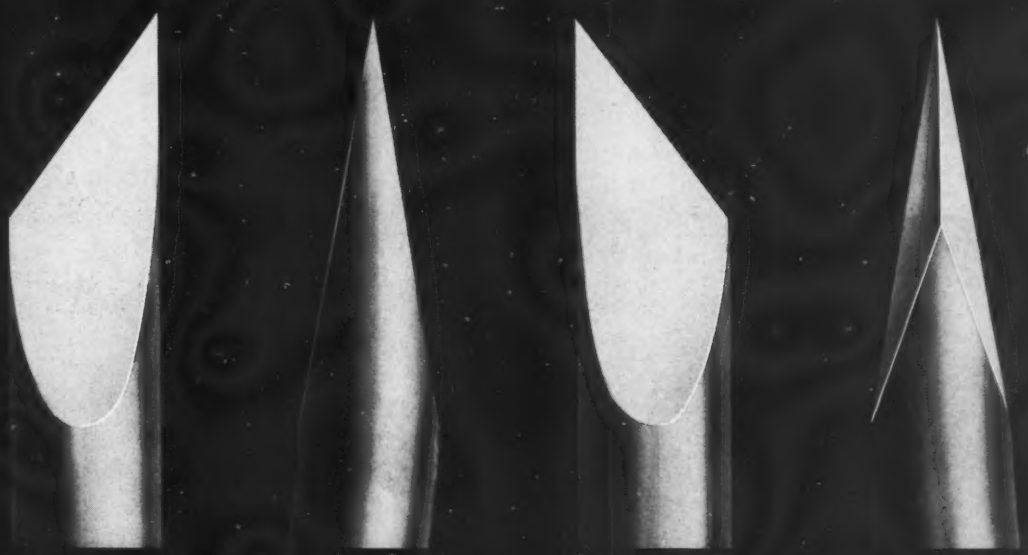

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Full Length Safety Sides. Like the ¾ Safety Sides at left, they're lightweight and easy to handle, yet ruggedly built for years of hard use. Can be fitted to all standard beds. Easily telescoped and folded back.

Telescopic Cubicle Curtain. Curtain swings away from bed for patient examination. Spring hinge eliminates damage due to accidental pulling. Can be telescoped to ⅓ its length and folded against wall. In 5 pastel colors.

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clinical notes

Enzyme Deficiencies Called Cause of Drug Reactions

Hypersusceptibility and hyposusceptibility drug reactions may be caused by genetic traits or enzyme deficiencies which are otherwise harmless, states Motulsky in the *Journal of the A.M.A.* 165:835-37 (October 19, 1957).

In a report to the A.M.A. Council on Drugs, the author points out that the mechanisms causing exaggeration or diminution of the usual effect of a drug are different from the immunologic mechanisms which cause toxic reactions in drug allergy.

It has been found that the enzymatic deficiencies which produce abnormal reactions to drugs often occur in ethnic groups and that the trait is genetically determined. In some groups, for instance, a chemical abnormality of red blood cells permits development of hemolytic anemia after administration of primaquine or related drugs. The abnormality has no known deleterious effect on the individual or the cell's life span otherwise.

Similarly, a genetically determined abnormality of folic acid metabolism may be responsible for the megaloblastic anemia sometimes produced by anticonvulsants. Liver damage caused by cinchophen, jaundice induced by chlorpromazine, and cinchonism produced by small doses of quinine or quinidine are other reactions possibly caused by genetic enzymatic defects.

Hereditary biochemical traits which cause drug reactions may be related to susceptibility or resistance to diseases other than drug-induced illnesses, the author says. In addition, hereditary, gene-controlled enzymatic factors may determine why, with identical exposure, some individuals become sick and others are not affected. It is thought that such factors probably affect many diseases.

Tranquilizer Found Effective As Relaxant During Labor

The tranquilizer promazine* is an effective adjunct to analgesia and sedation in labor, state Kuntze and Sison in the *American Journal of Obstetrics and Gynecology* 74:498-504 (September, 1957).

Excellent emotional and physical relaxation was obtained in 70 percent of 100 patients, in labor at term, who received 50 mg. of promazine intravenously, after regular contractions were established.

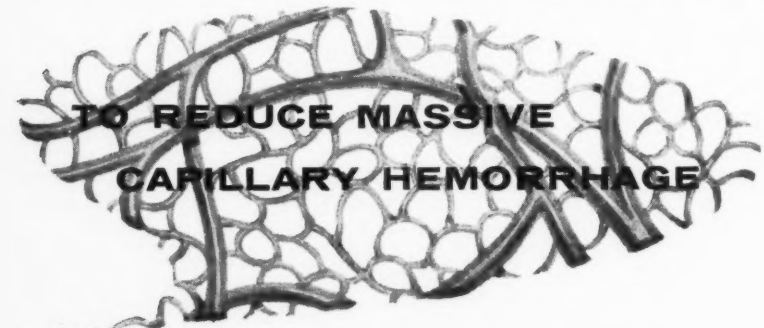
The duration of labor after medication appeared to be shortened, according to the authors, with no adverse effects on mothers or infants.

With the use of the tranquilizing agent, the authors noted a considerable improvement in the atmosphere of the labor room, with fewer demands on the nursing staff.

Barbiturates were eliminated as predelivery medication, and significantly lower amounts of analgesics were required. In addition, the authors found that delivery was accomplished under lighter, more transient anesthesia than is usually required.

The earlier in active labor the medication was given, the more satisfactory the response was. Best results were obtained when sufficient time was allowed for development of maximum sedative effect.

*Sparine hydrochloride (Wyeth).



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- In preparation of third degree burns for grafting
- Helps keep surgical field clean
- Plastic surgery
- Eye and brain surgery
- Reduces tissue trauma due to sponging

No systemic side reactions have been observed following its use.
It is free from protein material, is not antigenic, is well tolerated.
No untoward effects have ever been reported.

Kutapressin may be administered intramuscularly or subcutaneously.

Supplied: Aqueous Solution, 2 cc. ampuls; 10 cc., 20 cc. multiple-dose vials.

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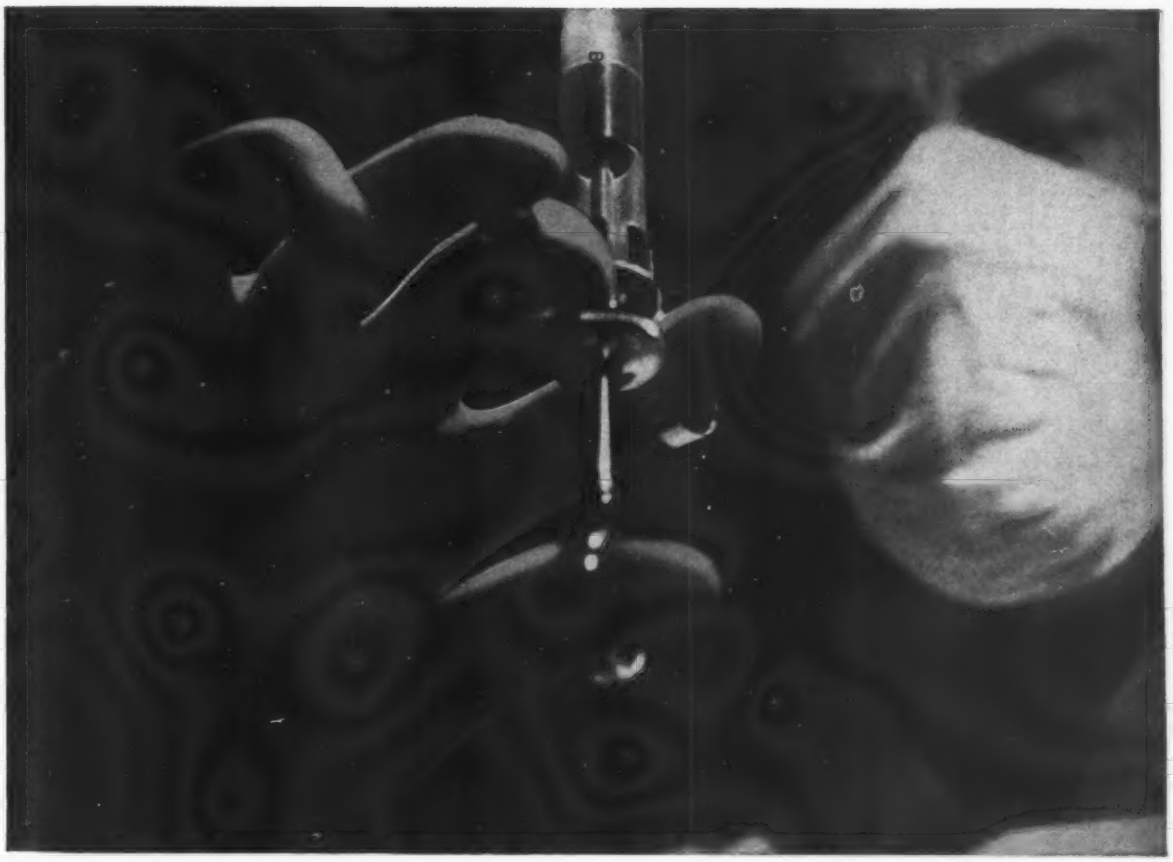

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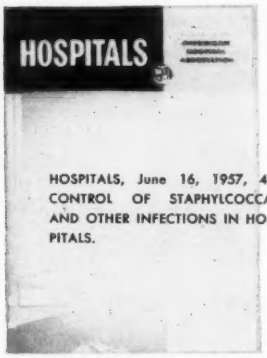

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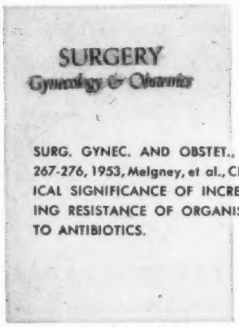
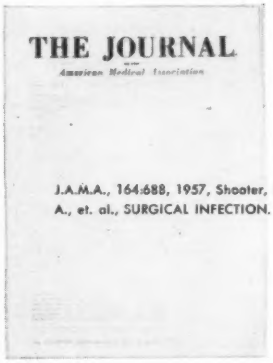
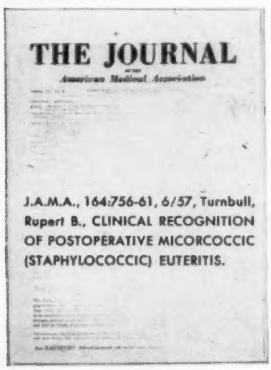


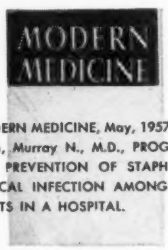
SURG. GYNEC. AND OBSTET., 92: 267-276, 1953, Melgney, et al., CLINICAL SIGNIFICANCE OF INCREASING RESISTANCE OF ORGANISMS TO ANTIBIOTICS.



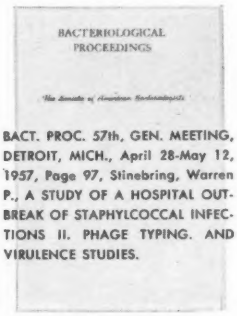
J.A.M.A., 164:688, 1957, Shooter, R. A., et. al., SURGICAL INFECTION.



J.A.M.A., 164:756-61, 6/57, Turnbull, Rupert B., CLINICAL RECOGNITION OF POSTOPERATIVE MICORCOCCIC (STAPHYLOCOCCIC) EUTERITIS.



MODERN MEDICINE, May, 1957, 73, Levin, Murray N., M.D., PROGRAM FOR PREVENTION OF STAPHYLOCOCCAL INFECTION AMONG PATIENTS IN A HOSPITAL.



BACT. PROC. 57th, GEN. MEETING, DETROIT, MICH., April 28-May 12, 1957, Page 97, Stinebring, Warren P., A STUDY OF A HOSPITAL OUTBREAK OF STAPHYLCOCCAL INFECTIONS II. PHAGE TYPING. AND VIRULENCE STUDIES.

BIBLIOGRAPHY

MODERN MEDICINE, May 1, 1957, 73, Levin, Murray N., M.D., PROGRAM FOR PREVENTION OF STAPHYLOCOCCAL INFECTION AMONG PATIENTS IN A HOSPITAL.

MEDICAL SCIENCE, May 25, 1957, Bahnson, Henery T., M.D., et. al., STAPHYLOCOCCAL INFECTIONS OF THE HEART AND GREAT VESSELS DUE TO SILK SUTURES.

"MEMORANDUM", May 22, 1957, Wetzler, T. F., M. PYOLGENES VAR. AUREUS. ITS IMPORTANCE IN HOSPITAL SANITATION. BACKGROUND AND DEVELOPMENT.

J.A.M.A., 164:83, 5/57, Lund, Flemming, RESISTANT MICROCOCCI.

J.A.M.A., 164:796, 6/57, MICROCOCCIC BRONCHOPNEUMONIC.

J.A.M.A., 164:756-61, 6/57, Turnbull, Rupert B., CLINICAL RECOGNITION OF POSTOPERATIVE MICROCOCCIC (STAPHYLOCOCCIC) EUTERITIS.

J.A.M.A., 164:201, May, 1957, MICROCOCCIC PNEUMONIA.

J.A.M.A., 164:321, May, 1957, Cook, et al., MICROCOCCIC DIARRHEA.

J.A.M.A., 164:688, 1957, Shooter, R. A., et. al., SURGICAL INFECTION.

J.A.M.A., 164:669, June, 1957, CROSS INFECTION FROM THERMOMETERS.

AMER. J. PUBLIC HEALTH, 47, (5):612-613, 1957, Bondi, Amedee, et. al., LABORATORY AND PUBLIC HEALTH ASPECTS OF THE INCREASE IN INFECTION DUE TO ANTIBOTIC-RESISTANT STAPHYLOCOCCIC.

LANCET. 1:446, 1950, Cairns, H. J. F., PENICILLIN-RESISTANT STAPHYLOCOCCIC.

SURG. GYNEC. AND OBSTET. 92:267-276, 1953, Melgney, et. al., CLINICAL SIGNIFICANCE OF INCREASING RESISTANCE OF ORGANISMS TO ANTIBIOTICS.

N. ENG. J. MED., 251:411-417, 1954, Howe, C. W., POST OPERATIVE INFECTIONS DUE TO S. AUREUS.

LANCET, 2:211-215, 1954, Clarke, S. K. R., et. al., CROSS-INFECTION WITH PENICILLIN-RESISTANT S. Aureus.

N. ENG. J. MED., 253:909-922, 1955, Findland, M., EMERGENCE OF ANTIBIOTIC-RESISTANT BACTERIA.

J. INF. DIS., 100:1-11, 1957, Sompolinsky, D., et. al., A SERIES OF POSTOPERATIVE INFECTIONS.

ANNALS NEW YORK ACADEMY OF SCIENCES, 65:65-66, 1956, McDermott, Walsh, THE PROBLEM OF STAPHYLCOCCAL INFECTIONS.

BACT. PROC. 57th, GEN. MEETING, DETROIT, MICH., April 28-May 2, 1957, Page 96-97, Cooper, M. L., et. al., ACUTE, SEVERE INFECTIONS IN YOUNG CHILDREN DUE TO MICROCOCCUS PYOGENES VARIETY AUREUS WITH A SPECIFIC BACTERIOPHAGE PATTERN.

BACT. PROC. 57th, GEN. MEETING, DETROIT, MICH., April 28-May 12, 1957, Page 97, Stinebring, Warren P., A STUDY OF A HOSPITAL OUTBREAK OF STAPHYLCOCCAL INFECTIONS II. PHAGE TYPING. AND VIRULENCE STUDIES.

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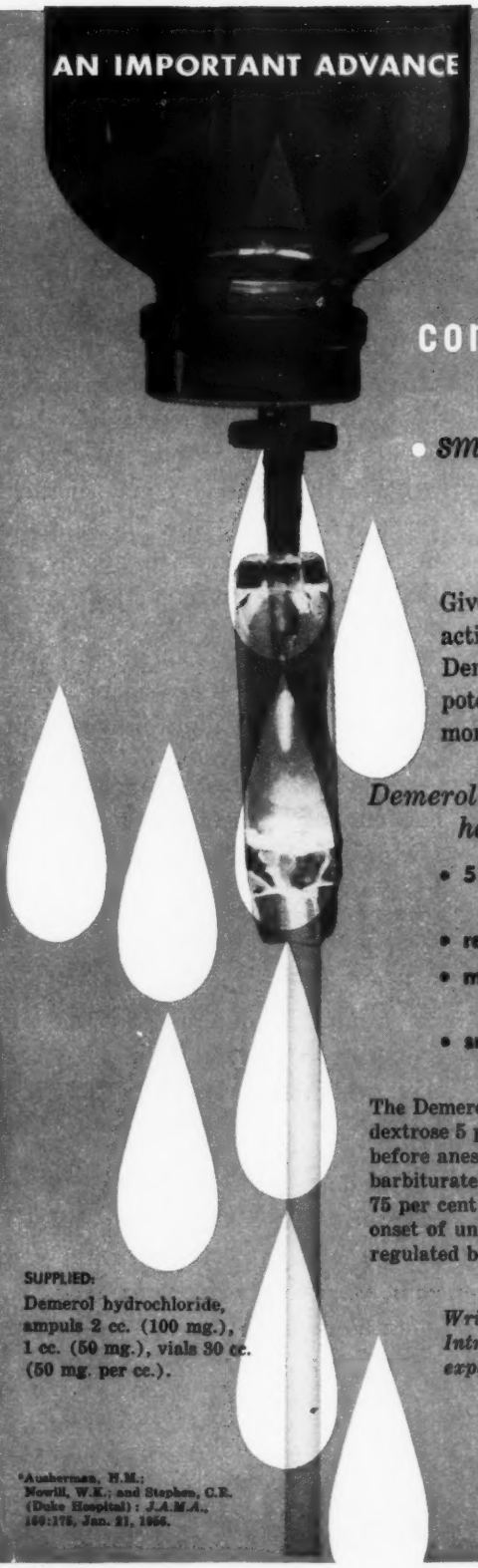

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The Demerol hydrochloride drip (250 mg. in 500 cc. dextrose 5 per cent in water or normal saline) is started before anesthesia is induced by the short-acting barbiturate (2 to 2.5 per cent solution). Nitrous oxide 75 per cent and oxygen 25 per cent is given after onset of unconsciousness; the amount of Demerol is regulated by respiratory rate, surgical trauma.

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*Ausherman, H.M.; Nowill, W.K.; and Stephen, C.R. (Duke Hospital): J.A.M.A., 160:175, Jan. 21, 1956.

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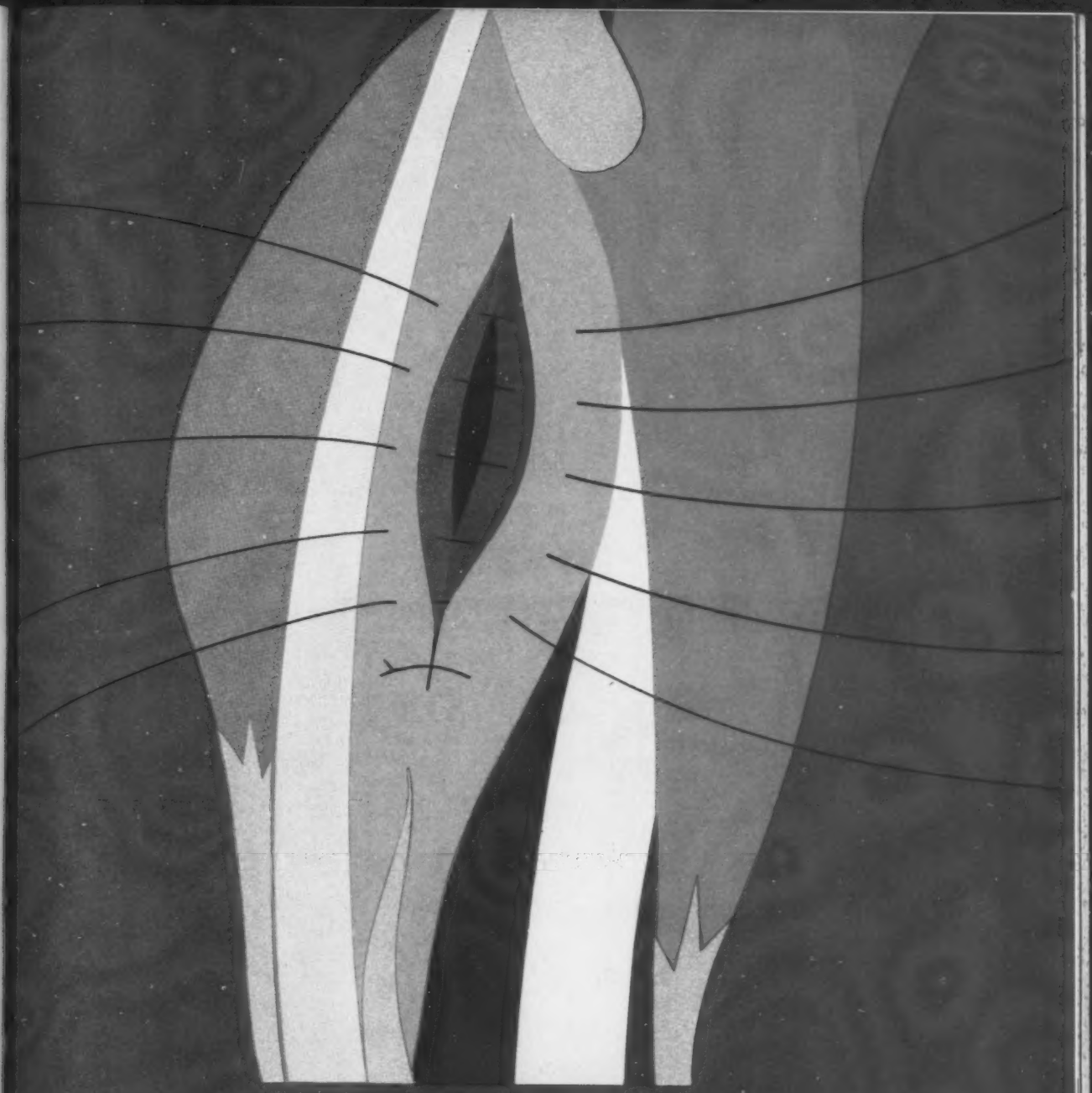

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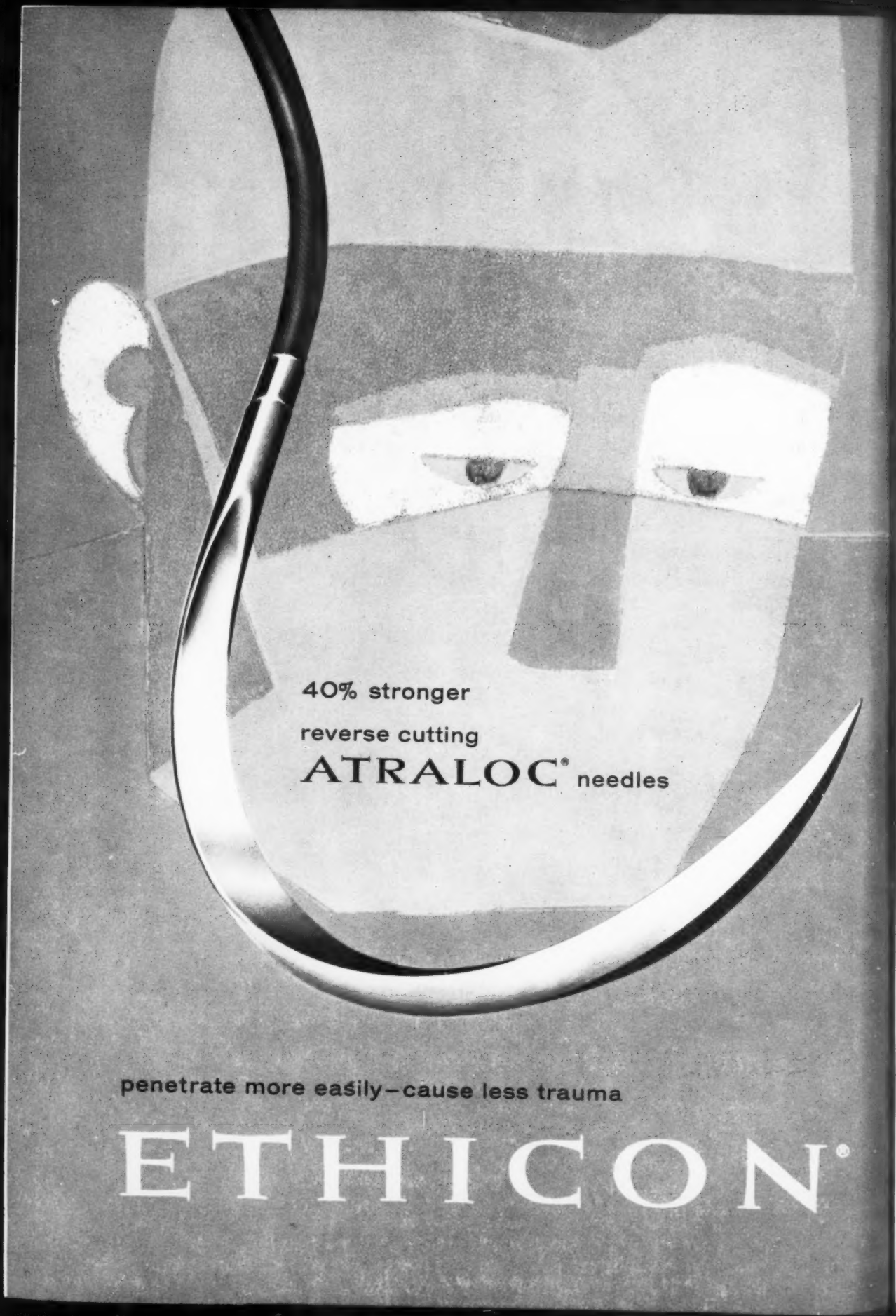
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Ilopan, recently released by the Warren-Teed Products Co., is for the prevention or relief of delayed intestinal peristalsis after major surgery and abdominal distention resulting from postoperative retention of flatus and feces. It is also suggested by the manufacturer for the relief of paralytic ileus.

Each cc. contains 250 mg. pantothenyl alcohol in distilled water.

The product is supplied in 2-cc. ampuls and in 10-cc. mutiple-dose vials preserved with 0.5% chlorobutanol.

Vitamin Formula

Filmtab Optilets-M, a new therapeutic vitamin formula with minerals, is now available from Abbott Laboratories.

Each tablet contains: vitamin A, 7.5 mg.; vitamin D, 25 mcg.; thiamine hydrochloride, 10 mg.; vitamin B_2, 5 mg.; nicotinamide, 150 mg.; vitamin B_{12}, 6 mcg.; ascorbic acid, 150 mg.; folic acid, 0.3 mg.; iron, 10 mg.; copper, 1 mg.; iodine, 0.15 mg.; cobalt, 0.1 mg.; manganese, 1 mg.; magnesium, 5 mg.; potassium, 5 mg.; zinc, 1.5 mg., and molybdenum, 0.2 mg.

Tablets, which come in Filmtab coating, are supplied in bottles of 50, 100, and 1,000.

Abbott has also announced a new product form — Filmtab Dayalets-M, replacing Filmtab Dayamineral. Dayalets-M come in apothecary jars of 100 tablets and in bottles of 250 tablets.

Management of Angina

Pentrasine, recently introduced by McNeil Laboratories, is intended to provide comprehensive management of angina pectoris by reducing the severity and frequency of attacks.

Each pink, scored tablet contains 10 mg. pentaerythritol tetranitrate, 10 mg. butisol sodium, and 0.05 mg. reserpine. Tablets are supplied in bottles of 100 and 1,000.

Oral Penicillin

V-Cillin K (penicillin V potassium, Lilly) is a new oral penicillin which is said to reach high therapeutic levels within 15 minutes.

Maximum levels attained, according to the manufacturer, are four times as high as those of penicillin-G and double those of penicillin V. V-Cillin K tablets are designed to disintegrate in stomach acids within about five minutes.

The product is supplied in scored tablets of 125 mg. and 250 mg. The 125-mg. tablets come in bottles of 50, and the 250-mg., in bottles of 24.

Urethral Suppositories

Furestrol suppositories, for the control of postmenopausal urethritis, are a new form of Furacin urethral suppositories to which estrogen has been added.

Each Furestrol suppository contains Furacin 0.2%, diperodon hydrochloride 2%, and diethylstilbestrol 0.0077% (0.1 mg.) in a water-dispersible base.

The suppository melts at body temperature to form a lasting, water-miscible film.

Eaton Laboratories supplies the product in boxes of 12.

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Panalba is a combination of two potent antibiotics, Panmycin phosphate (tetracycline phosphate complex) and Albamycin (novobiocin sodium). It is designed for the treatment of mixed infections.

Each capsule contains tetracycline phosphate complex equivalent to 250 mg. of tetracycline hydrochloride and 125 mg. of novobiocin.

Panalba is supplied by the Upjohn Co. in bottles of 16 and 100 capsules.

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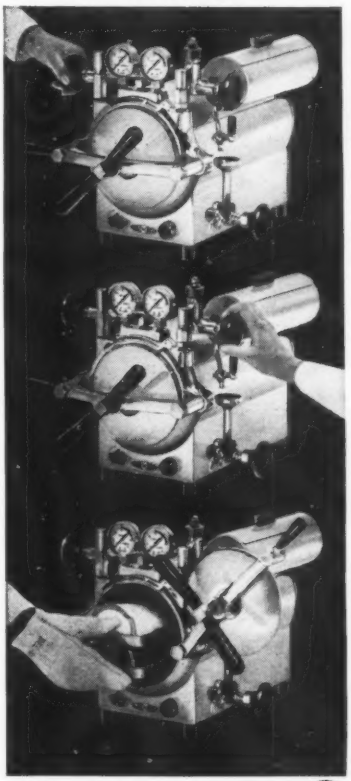

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When sterilization is completed, discharge steam to condenser after closing transfer valve and crack open the door.

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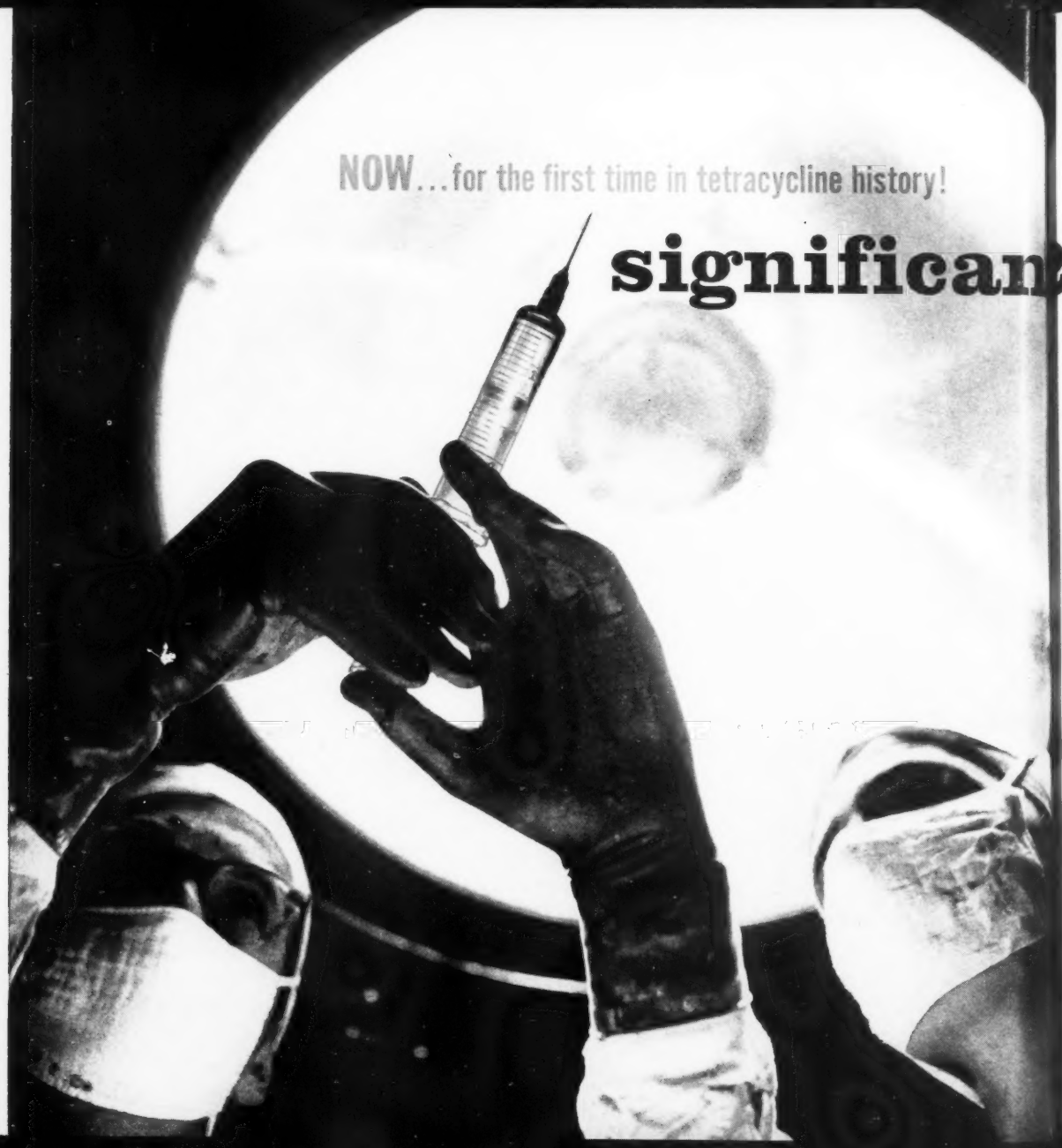

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HOSPITALS VISUALIZED. By Ray E. Brown and Richard L. Johnson. Chicago: American College of Hospital Administrators. Revised edition. 1957. 134 pp. $1.50.

Four new chapters, covering safety, chaplain service, nursery, and medical staff, have been added to the new edition of this handbook. Written in question form, the text is designed to serve as a teaching aid for students of administration, as well as a check list for administrators and department heads reviewing administrative functioning. Text covers departments from accounting to x-ray, with questions applicable to both large and small hospitals.

The new chapter on chaplain service includes questions on organizational policies and procedures, patient care services, records, and physical facilities.

Questions on problems of physical layout, equipment, patient care, and formula room for nurseries have been separated from questions on general nursing service and compiled in a separate unit. Similarly questions on safety, previously appearing in various sections, have been brought together to facilitate planning an organized safety program. A number of questions have been added covering new developments and regulations.

The book is available from the College through its publications department, 620 N. Michigan Ave., Chicago.

Guide to Poisons

ACCIDENTAL POISONING IN CHILDHOOD. By Edward Press, M.D., Springfield, Ill.: Charles C Thomas. 1956. 131 pp. $3.

This volume summarizes the available literature on the chemical constituents of common household substances and the most recent, approved methods of treatment. Compiled by the Committee on Accident Prevention of the American Academy of Pediatrics, the book is designed to serve as a reference guide for practicing physicians as well as a means of encouraging and organizing Poison Control Centers.

For easy reference, the book is composed of three colored sections. Section I deals with treatment procedures; Section II is a table of poisons, each item referring to the appropriate procedure in section I; and Section III contains identification of the primary toxic ingredients of various household products and also references to publications containing more extensive lists.

The final section contains tables listing the toxic ingredient of several hundred common household substances as well as in about 40 poisonous plants found in the United States.

Several blank pages are included for notes at the end of the book.

The book was published through a grant to the Academy from Johnson & Johnson, New Brunswick, N.J.

The author is field director, American Public Health Association, and chairman, Subcommittee on Poisoning, American Academy of Pediatrics.

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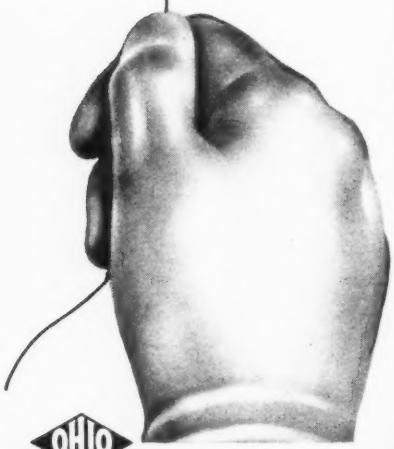

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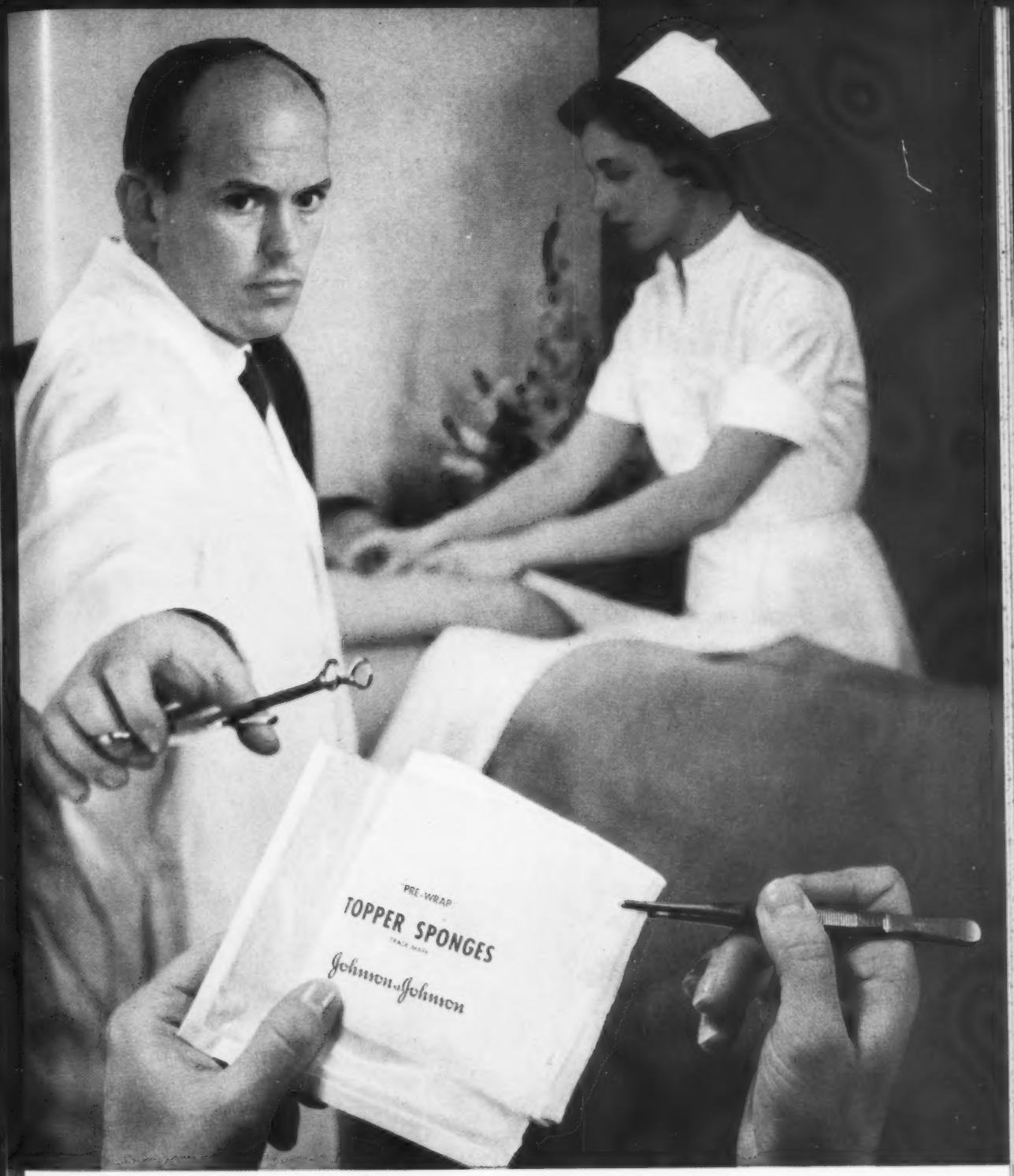

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The Etiology of Puerperal Mastitis and Infections Of the Newborn*

By K. Knörr and A. Wallner†

• The antibiotics have played an important part in diminishing the dangers of obstetric and gynecological infections. Certain diseases, such as puerperal sepsis, greatly feared in former days, are rarely seen now. Other infections, however, have been only temporarily controlled by antibiotics. These are puerperal mastitis and the infections of the newborn. Despite the use of antibiotics these conditions are still quite prevalent (Noack, Unsheln). The etiology and increasing frequency of these conditions has been investigated, because they are a threat to mothers and babies in maternity hospitals.

The type of causative organisms, as well as its distribution throughout the hospital, were determined. The chief aim was to ascertain the mode of transmission in order to plan prophylactic measures. In addition, sensitivity tests with the usual antibiotics were performed once the organism had been isolated.§

MATERIAL AND METHODS

One hundred and five swabs were obtained from the nasopharynx, hands and surgical masks of the nursing staff of the nurseries; 125 swabs were obtained from the nasopharynx and conjunctivae of newborn babies on different days after birth; 121 swabs were taken from the nipples and vagina of mothers before and after delivery; 88 bacteriological tests were performed of the environment of nursery, lying-in wards, general wards and operating theater; 36 swabs were obtained from mastitis pus and infections of the newborn.

All material for investigation was inoculated on 10 percent (sheep) blood agar, lactose fuchsin agar (after Endo), liver broth and acid-dextrose broth (Difco). The incubation period of the media inoculated with the material on the day on which it had been obtained usually lasted 24 hours; in exceptional cases, when there was scanty growth after one day's incubation or after transplantation on enriched media, 48 hours were allowed. Special attention was paid to the growth of staphylococcus pyogenes: the plasma coagulase test was used for identification in addition to its typical growth on blood agar (form of colonies, formation of pigment and hemolysin).

RESULTS

The hemolytic streptococcus, so greatly feared in obstetrics, was never found in mastitis pus and only very rarely in any of the other specimens.

1. We have confirmed the findings of other investigators (Muth, Noack, Unshelm), that the hemolyzing staphylococcus (*Staphylococcus aureus hemolyticus, M. aureus*) is, for practical purposes, the only causative organism of puerperal mastitis and infections of the newborn. With the exception of two specimens this organism was found in the pus of all patients with mastitis. It was contained in all specimens from newborn babies with infections. The remaining organisms, e.g. the nonhemolyzing streptococcus, the pseudo-diphtheria bacteria, cocci of the catarrhalis group and sarcina, should be regarded as nonpathogenic. (Fig. 1.)

2. As for the source of infection of *S. aureus* and its mode of transmission, bacteriological investigations of the environment revealed that the organism was widespread in lying-in wards. Fig. 1 illustrates that this organism (hemolysin formation and positive coagulase reaction) was present in the nasopharynx of two-thirds of all maternity nurses investigated. It was also found almost invariably on the hands of nurses, despite the antiseptic measures customary in post-natal care (disinfection of hands).

Furthermore, it was found that *Staphylococcus aureus* was generally and permanently present in the lying-in wards and the nurseries. Agar slides were exposed for an hour at various times of the day and night in the nurseries and lying-in wards. Almost invariably there was a growth of *Staphylococcus aureus* on the culture medium, whether the slides had been exposed during the rest or during the treatment periods.

Approximately 90 percent of all newborn babies had *Staphylococcus aureus* in their nasopharynx (Fig. 1).

(Continued on next page)

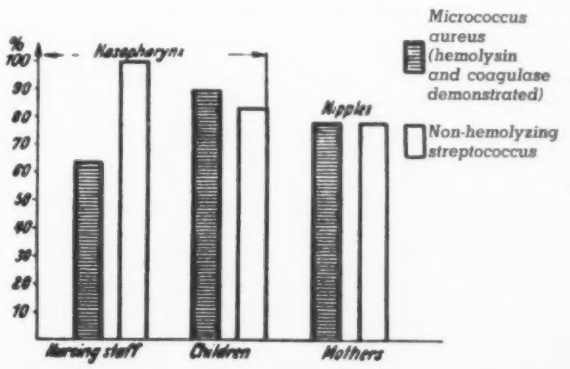


Fig. 1. Frequency (in percent) with which the causative organism was found on the mother's nipple, or in the nasopharynx of the nursing staff or the newborn.

*Reprinted with permission from the *German Medical Monthly*, p. 240, Vol. 1, No. 8, August, 1956. Translation of article in the *Dtsch. med. Wschr.* p. 1219, Vol. 81, 1956.

†From the Department of Gynecology, University of Tubingen, Tubingen, Germany.

§All bacteriological tests were performed by Dr. Lang of the Institute of Hygiene, University of Tubingen.

This organism was also found on the nipples of about 80 percent of the mothers (Fig. 1). As for the mode of transmission it seems particularly important to note that the organism was generally only found in the nasopharynx of babies after their second day of life and usually on the mothers' nipples after the third day of confinement.

The micrococcus invaded the eyes of the newborn babies on the second or third day after birth. It was found in three-quarters of all eye swabs beyond that stage. Whenever a conjunctivitis was present the organism could invariably be detected. Previous prophylactic measures (after Credé), such as silver nitrate or penicillin eye drops, proved of no avail. The organism is, however, never or hardly ever found in the vagina, either before or after delivery, nor is it found in the lochia.

The following possibilities of the origin of puerperal mastitis are revealed from these results:

The organism enters the nasopharynx of the newborn during the course of the first few days of life, which the baby spends in contaminated surroundings, particularly in the bacteria-laden atmosphere of the nursery, and by contact with the nursing staff. As a rule the organism is traced to the babies' nasopharynx sooner than the mothers' nipples, and it must be assumed that it is transmitted to the nipple during breast feeding (contrary to the view of Breuning and Harnisch). A direct transmission of this universally present organism via the nursing staff or other ways to the nipples is hardly likely.

Only in exceptional cases are the causative organisms of mastitis contained in the lochia, which hardly ever grow *Staphylococcus aureus*. Thus the usual mode of infection appears to be the transmission of the organism from the nasopharynx of the nurses or the contaminated air to the babies' nasopharynx and from the mothers' nipples. Local infection will be even more likely should there also be fissures (See Table I).

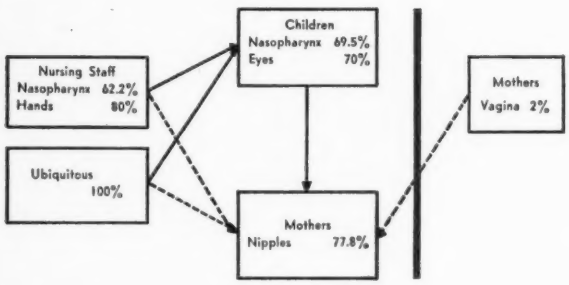


Table I. Frequency (in percent) with which Micrococcus aureus was found in the various groups; and diagrammatic representation (arrows) of the probable mode of transmission in the maternity wards.

Up to the present it has been generally assumed that the causative organism of mastitis mainly originated from infected lochia. Precautionary measures were taken and different nurses were allocated to carry out vaginal and nipple care. These precautions are still customary today. In view of our findings it is hardly surprising that these procedures have done little to prevent puerperal mastitis.

It is equally unlikely that nonspecific conjunctivitis of the newborn originates to any extent from the mother's vagina (as postulated by Zimmer and Kremser), as the presence in the vagina of the responsible organism, either before or after delivery, can only be rarely demonstrated. It must rather be assumed that the pathogenic micrococci are transmitted to the babies' eyes after birth. The nursing staff must be considered largely responsible in view of the frequency with which this organism could be found in the nasopharynx of the attending nurses. Because of their universal presence these organisms are liable to invade the conjunctivae.

SENSITIVITY TESTS

The results of sensitivity tests further confirm the mode of transmission that has been suggested.

The resistance of bacteria to certain antibiotics must be regarded as a genetically conditioned trait which is produced by spontaneous mutation. The antibiotic only acts in the sense of "selecting" resistant organisms. The studies of Lederberg with the replica method and the transmission of hereditary factors, as elaborated by Hotchkiss and Alexander, prove this point.

The determination of resistance of the various strains of Micrococcus pyogenes was carried out by the "hole" test. Ten percent sheep blood agar was used as a medium which was coagulated in a Petri dish, 11 cm. in diameter, to a height of approximately 6 mm. A drop of a 24-hour broth culture of the strain to be investigated and of the SG 511 strain was spread on blood agar plates. After drying for 50 minutes 8 holes of 1 cm. diameter were punched out and each was filled with 0.1 ml. (500 y) of streptomycin, terramycin, tetracycline, aureomycin, chloromycetin, erythromycin, 0.1 ml. (10 I. U.) of penicillin and 0.1 ml. (500 y) of the sulfonamide "Protozid" and incubated for 16—20 hours at a temperature of 37°C. This relatively high concentration of the various antibiotics was chosen in order to obtain easily distinguishable differences in their inhibitory action.

The interpretation was done by comparing the results with those obtained on the SG 511 strain. The strains which grew up to the punched-out hole were regarded as resistant; those showing inhibition of growth for 1—2 mm. around the hole as weakly sensitive; those in which the sensitivity zone was 1.2 mm. smaller than that of the SG 511 strain as moderately sensitive; those with zones of inhibition equal to SG 511 as sensitive and those with zones larger than SG 511 as very sensitive. In each experimental series the SG 511 strain was used as a control for the quality of the medium and to assess its sensitivity. In this way it was possible to take into account small variations in the medium.

The bacteria which were isolated were resistant to the more recent broad-spectrum antibiotics or at least only weakly sensitive (Table II). Only erythromycin and, much less regularly, chloromycetin were found to be effective. It must, however, be emphasized that the number of organisms which are sensitive to erythromycin was considerably higher six months ago and has declined considerably during this period. Thus, even within this short period, signs of increased resistance have become apparent, although erythromycin was only rarely used clinically and reserved for the more serious cases.

Table II. Resistance (or sensitivity) of the causative organisms. (Swabs of mothers' nipples, nurses' and newborn's nasopharynx, and plates exposed in nursery and maternity wards)

	resistant	weak	moderate	good	very good
Protozid	68%	2%	17%	12%	1%
Streptomycin	41%	12%	19%	22%	6%
Penicillin	33%	25%	29%	9%	4%
Terramycin	23%	23%	13%	32%	9%
Tetracyline	22%	28%	13%	28%	9%
Aureomycin	10%	38%	11%	34%	7%
Chloromycetin	1%	6%	31%	42%	20%
Erythromycin	——	1%	9%	42%	48%
		795=60%		541=40%	

Table II demonstrates the microörganisms' resistance to the various antibiotics. These results more or less applied to the entire maternity department. There is no appreciable difference between the organisms obtained from the nasopharynx of the nursing staff or the babies, from the mothers' nipples on the second to third hospital day, or from the pus of mastitis developed during the hospital stay. These findings further support the postulated mode of transmission.

Occasionally *Staphylococcus aureus* was found on the nipples upon admission to hospital. This strain, however, generally proved to be very sensitive to antibiotics, even to penicillin, but after a few days a certain amount of resistance developed (Table III). Eventually the strain would achieve a degree of resistance which corresponded to that prevalent in the lying-in wards. It must, therefore, be assumed that there repeatedly occurred, in the course of breast feeding, the transmission of the hospital's strain to the mothers, until this strain finally predominated (Napp and Clauss).

Table III. Change of resistance (or sensitivity) of Micrococcus aureus during the hospital stay. (Symbols: —resistant: —; weakly sensitive: ((+)); moderately sensitive: (+); sensitive: +; highly sensitive: ++.

Nipple swabs	Strepto-mycin	Peni-cillin	Terra-mycin	Tetra-cycline	Aureo-mycin	Chloro-mycetin	Erythro-mycin
on admission	+	+	+	+	++	++	++
before the first breast feeding	+	+	+	+	++	++	++
on day 3	((+))	(+)	(+)	((+))	++	+	++
on day 4	(+)	(+)	(+)	(+)	+	+	++
on day 6	(+)	—	(+)	((+))	(+)	+	+
on day 7	(+)	—	—	—	((+))	+	(+)

Similar observations were made in cultures of the bacteria obtained from mastitis pus. If mastitis occurred after a home confinement, the causative organisms were in our experience almost invariably sensitive to all antibiotics, providing there had been no previous antibiotic treatment. If, however, the mastitis had its onset after delivery in hospital the strains were markedly resistant, even though the actual infection may only have developed after discharge from hospital.

The time interval between discharge from hospital and the onset of mastitis appeared to be of no significance; in some cases it even amounted to several weeks. Thus it is probable that mastitis arising after discharge was caused by the bacterial strain acquired during the hospital stay. The view that hospitalization is not responsible for mastitis developed after discharge can no longer be accepted. Frequently it is possible to decide from bacteriological results and factors of sensitivity or resistance, whether delivery had taken place at home or in hospital.

CONCLUSIONS

The practical measures which arise from these investigations will be chiefly concerned with eliminating the possibility of transmission and growth of staphylococcal strains. Only then will the perils of maternal and infant infections with this extremely resistant organism be reduced, and in this way alone will the administration of antibiotics be reduced and the risk of increasing resistance be avoided.

It is of great importance to have small ward units within a postnatal department, so that the rooms can be emptied and thoroughly disinfected at frequent intervals. The results of tests carried out in operating theaters and general wards indicate the value of such measures. The fact that *Staphylococcus aureus* is only rarely found there must be generally attributed to the regular and frequent disinfection by scrubbing.

It is not known, as yet, whether aerosols are suitable for the elimination of bacteria in rooms, and further developments in this field must be awaited. Ultraviolet radiation has so far not shown any satisfactory results. Regarding the disinfection of hands, substances with a prolonged action will be particularly important (Kliewe and Lammers.)

The surgical masks generally used contained a multitude of pathogenic organisms a short while after use. They should be changed frequently and not be touched by hand.

Care of the nipples continues to be important. The possibility of increasing resistance must be considered when antibiotic ointments are applied to the nipples (Schultz).

SUMMARY

In the last few years there has been a considerable increase in the number of cases of mastitis and infections of the newborn. In the majority of instances such diseases, when they do occur nowadays, are caused by antibiotic-resistant bacteria which can be demonstrated to be widespread in the air of newborn and obstetric wards, and in the nasopharynx of the nursing and medical staffs.

Swabs were taken from the nasopharynx, hands and oral mucosa of the nursing staff; from the nipples and vagina of the mothers; and from the conjunctivae of the newborn. In addition bacteriological analyses were made of the air and furniture in wards and operating theaters where mothers and newborn babies had been.

Micrococcus aureus (*Staphylococcus aureus*) was practically the sole causative agent of puerperal mastitis. Vaginal and lochial flora play no role as sources of infection in this condition. Antibiotic-resistant bacteria first occur in the nasopharynx of the newborn and only later on the mother's nipples.

From this it is assumed that they reach the nasopharynx either from the bacteria-containing air of the wards or more directly from the nursing staff and are then transmitted to the mother's nipples during nursing.

A similar mode of transmission can be assumed for the nonspecific conjunctivitis of the newborn (i.e. air, nasopharynx and hands of nursing staff).

The mastitides which occur after discharge from hospital are believed to have been acquired in hospital in the described manner.

REFERENCES

Alexander, H. E., u. a.: J. Exper. Med. 97 (1953), p. 17. — Berker, F., Napp, J. H.: Dtsch. med. Wschr. 78 (1953), p. 470. — Breuning, M., Harnisch, R.: Zbl. Gynak, 77 (1955), p. 1430. — Heilmeyer, L.: Beitr. z. Kl. d. Tub. 111 (1954), p. 55. — Hotschkiss, D. R., et. al.: Cold Spring Harbor Symp. Quant. Biol. 16 (1951), p. 457; 2. Congr. Intern. Biochem., Paris 1952, p. 40. — Kliewe, H. Lammers, Th.: Dtsch. med. Wschr. 81 (1956), p. 124; 81 (1956), p. 156. — Lederberg, J., et al.: Nature 158 (1946), p. 558; 164 (1949), p. 150. — Muth, H.: Dtsch. med. Wschr. 75 (1950), p. 1072; Med. Klin. 47 (1952), p. 739; Geburtsh. u. Frauenhk. 14 (1954), p. 74. — Napp, J. H., Clauss, J.: Geburtsh. u. Frauenhk. 10 (1950), p. 799. — Noack, H.: Geburtsh. u. Frauenk. 15 (1955), p. 224. — Schultz, W.: Geburtsh. u. Frauenhk. 15 (1955), p. 936. — Unsheim, E.: Zbl. Gynak. 76 (1954), p. 1312. — Walter, A., Heilmeyer, L.: Antibiotika-Fibel. (Stuttgart 1954.) — Zimmer, K., Kremser, R.: Geburtsh. u. Frauenhk. 15 (1955), p. 628.

Left: Expectant mothers get child care information from experts—seven young mothers and a pediatrician. Tom Callahan, three-year-old cowboy, helps Francis Kodl, M.D., give the final lecture. The mothers, all patients of Dr. Kodl, are: Mrs. Thomas Callahan; Mrs. John Karras and John, two; Mrs. George Wesbey and George, 18 months; Mrs. George Supplitt and Peter, 1; Mrs. Loren Horton and Jan six months; Mrs. Richard Arend and Jacqueline, three months; and Mrs. Eugene Foster and Kimberly Suzanne.

ANTICIPATORY GUIDANCE GIVEN FOR EXPECTANT PARENTS

● Five free courses for expectant parents, held each year since 1949 at MacNeal Memorial Hospital, Berwyn, Ill., are sponsored by the hospital as a community service.

Pediatricians, obstetricians, dietitians, nurses and mothers give the weekly lectures. Eight lectures are slanted for the mothers-to-be, and one, given by an obstetrician, is specifically designed for the father-to-be.

The course follows a chronological order from the time the mother becomes pregnant until the baby is three years.

The first class is given by a resident doctor. It acquaints the mother with anatomy and physiology as it relates to pregnancy. Growth and development of the baby are discussed. Emotional effects of pregnancy are explained to allay fears and apprehension. The movie "Human Reproduction" is shown as a teaching aid.

The next class is divided into two parts. During the first part, an obstetrician discusses the proper care for the expectant mother during pregnancy. The movie "Prenatal Care" is shown. During the second part, the mothers tour the maternity floor, viewing patients' rooms, nurseries, and the labor and delivery rooms. A delivery room nurse explains the hospital procedures.

In the third class period a dietitian explains the importance of proper nutrition and a balanced diet for the mother during pregnancy. The movie, "Something You Didn't Eat," emphasizes the lecture.

The labor and delivery room supervisor conducts the fourth class during which the expectant mother is given an understanding of how a baby is born. The material covered includes: early signs of approaching labor, immediate signs of labor, what to report to the doctor, when to come to the hospital, stages of labor, how to relax during labor, and the birth. The movie "Labor and Delivery" is presented.

The nursery supervisor takes over the fifth class. Identification methods such as footprints and name bracelets are explained. The baby's feeding schedule in the hospital is discussed, as well as care of the cord, and circumcision. A sponge bath is demonstrated, followed by the movie, "Baby's Tub Bath."

The obstetrical supervisor, in the sixth class, explains the baby's physical needs, breast feeding, and different types of nursing bottles. The proper way to hold a nursing bottle when feeding the baby is demonstrated and the feeding schedule is explained. Then comes a practice session on changing diapers and fixing layettes. The class closes with the movie "Know Your Baby."

Formula preparation is the subject of the seventh class, conducted by the obstetrical supervisor.

Above: Warren Winkler, M.D., Berwyn, Ill., gives father-to-be Allen Rose advice on what to expect when baby comes. The baby, serving as a model is Jeffrey Peterson, twin son of Mr. and Mrs. Charles Peterson, Cicero, Ill. In a special night class father gets to tour the labor and delivery room.

A pediatrician conducts the final class. A panel of mothers discuss the behavior and development problems they have encountered with their children. Seven babies, from three weeks to three years old, act as models. The doctor discusses the advantages and disadvantages of breast and bottle feeding, and also covers weaning, toilet training, thumbsucking, and other problems. "Children's Emotions" is the final movie.

The course is supervised by Amy Johnson, R.N., obstetrical supervisor; Gardis Dahle, R.N., delivery room supervisor; and Mable Wilen, R.N., nursery supervisor. Members of the women's auxiliary take attendance and serve milk, juices, and cookies during the lectures.

Below: Amy Johnson, R.N., obstetrical supervisor, presents diplomas to three graduating members of Expectant Mothers' Course at MacNeal Memorial Hospital. The graduates with Miss Johnson are (l. to r.): Mrs. Robert G. Lambert, La Grange; Mrs. Frank Hajek, Berwyn, and Mrs. John Yelnick, La Grange.

Emotions, Tranquilizers Discussed at Academy Meeting

Pediatrics

Over 3,500 doctors and guests gathered at the Palmer House for the American Academy of Pediatrics' 26th annual meeting, October 7-10. TOPICS report follows:

Hospitalization May Help Resolve a Crisis

Children's Hospitals Should Adapt Better to Needs

Hospitalization of a child is often associated with multiple psychological disorders within a family, at times of crisis proportions. Hospitalization may be complicated by a preceding crisis, or may itself produce a crisis. If properly managed, a hospital stay may help to resolve a problem.

Liberalization of the visiting policy introduces difficulties in the management of a case. However, it has the advantage of giving the hospital team additional knowledge of the child in his family background, resulting in better over-all care.

Before hospitalization can be used to maximum benefit in all but emergency cases, non-hospital rehabilitative measures for the social and emotional structure of the family should be attempted.

The ultimate advantage of special hospitals for children rather than facilities in general hospitals, is their ability to adapt themselves to the child's needs.

Children's service personnel must be sympathetic toward a family emotional crisis which precedes hospitalization, as well as any arising in the course of hospitalization.

The co-operation of all involved in the care of the child is necessary to solve these crises.—**John A. Rose, M.D.**, Director, Child Guidance Clinic; Chief, Department of Child Psychiatry, Children's Hospital, Philadelphia, Pa.

Tranquilizers Have Place In Regulating Child's Behavior

Other Means of Psychological Management Should Be Employed

Tranquilizing drugs can be useful to modify a child's behavior difficulties. They reduce, or eliminate many troublesome symptoms.

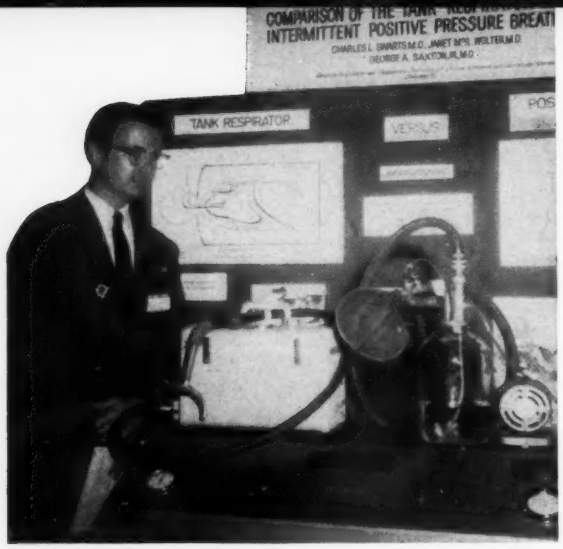
If tranquilizers make children "easier to live with" and contribute to an improved social adjustment, their use is worthwhile.

The indirect effects on children's behavior of improvements in the attitudes toward them of their parents, teachers, and playmates, may be more important than the direct effect on the child of the medication itself.

Until more information is accumulated concerning the precise mode through which tranquilizers alleviate specific

(Continued on next page)

Left: Stewart H. Clifford, M.D. (center), associate professor of pediatrics, Harvard Medical School, and chief pediatrician, Boston Lying-In Hospital, became the new president, American Academy of Pediatrics. Edgar E. Martmer, M.D. (r.), chief of pediatrics, Harper Hospital, Detroit, is the retiring president. James C. Overall, M.D. (l.), clinical professor of pediatrics, Vanderbilt University School of Medicine, Nashville, was elected vice-president.



Above: Edgar C. Sweeney, M.D., attending staff, Charlotte Memorial Hospital, Charlotte, N. C., looks at an exhibit explaining the comparison between tank respirators and intermittent positive pressure breathing, prepared by the respiratory center and pediatric department, University of Illinois Research and Educational Hospitals.

behavior symptoms, it is impossible to select accurately a drug for use in a particular clinical problem.

There are three major areas of use for tranquilizers in pediatric patients:

- For emergency management of a severely disturbed or overactive child a tranquilizer may be given parenterally. It is useful, for example, for a youngster entering the hospital or facing weeks in traction.

- For calming a child before a potentially frightening experience such as the changing of burn dressings a tranquilizer given orally, an hour or two preceding will put the child at ease.

- For handling children with chronically explosive or aggressive behavior, or certain deep set emotional problems, tranquilizers may be given to obtain freedom from disturbing symptoms.

Tranquilizers can be an aid to the pediatrician dealing with emotionally upset children in areas where psychiatric help is not available.

Although tranquilizing drugs may be used for the relief of symptoms, in the total treatment of emotionally disturbed children their use should be accompanied by other available forms of guidance and psychological management.—**Charles Bradley, M.D.**, Associate Professor of Pediatrics and Psychiatry, University of Oregon Medical School, Portland.

Skin Rashes Not Always Caused by Food Allergy

Clothes Found to Be Primary Cause

Contact eczema, as seen in young children, differs from contact eczema in adults, in that it is more likely to be due to the clothes than to anything else. Primary irritants of relatively low power are more likely to cause eczema in children than in adults.

Two-hundred consecutive cases of eczema in children from seven weeks to 14-years of age were studied. Fifty-three of these were thought to be caused by outside contact with irritating materials. Forty of the 53 cases were probably caused by something connected with clothes. Wool is the commonest cause of contact eczema, then diapers, plastic and synthetic fibers, and underwear. Toilet-seat dermatitis is not common. Other irritating materials include: nail polish, shoe linings and bib and mattress covers.

Of the 53 cases thought to be caused by outside contact with an allergenic material, the cause was determined in 30, probable cause in 18, and in four it was unknown.

Too many children are given diets for eczema when the cause is really something which contacts the skin from the outside.—**Lewis Webb Hill, M.D.**, Boston.

Childhood Tuberculosis Complications Prevented with Isoniazid

Three-Year Study Made On 2,750 Children

Isoniazid appears effective in preventing the serious, often fatal, complications of asymptomatic primary tuberculosis in children.

Pediatricians in 33 pediatric clinics in the United States, San Juan, Puerto Rico; Mexico City, and Toronto have been observing 2,750 children with primary tuberculosis since January, 1955. The study, designed to test the efficacy of isoniazid as a preventive, was directed by Frank W. Mount, M.D., and Shirlee Ferebee, United States Public Health Service, Washington, D.C. It was supported in part by a grant from the National Tuberculosis Association.

Half of the children took isoniazid, in doses of four to six mg. per kilogram of body weight, every day for a year.

Left: Sol Roy Rosenthal, M.D., Institution for TB Research, University of Illinois, Chicago, shows (l. to r.): Jacinta Salazar, M.D., Liwanag Roman, M.D., and Yolanda Torralba, M.D., all pediatric residents, Homer Phillips Hospital, St. Louis, how to administer a BCG vaccination with the newly developed multiple puncture disc method.

The other half took placebos. As soon as an unfavorable condition requiring treatment with antituberculosis drugs appeared, the child was removed from the test of isoniazid's preventive possibilities and was given specific antituberculosis treatment.

During the first year of the study 26 percent of the children given placebos developed extrapulmonary complications while only five percent of those given isoniazid did, indicating that the drug prevented at least 80 percent of the complications of childhood tuberculosis in this group. Children under one year who had tuberculous infection, and older children with parenchymal disease were at the greatest risk for developing serious complications. Children over one year who had negative initial x-ray findings appeared to have little risk of immediate complications.

Investigations are being continued in the children through the adolescent period to determine the effect of isoniazid on the later development of chronic pulmonary tuberculosis.—**Frank W. Mount, M.D.,** United States Public Health Service, Washington, D.C.

Left: Ella M. Salmonsen (r.), chief, medical department, John Crerar Library, shows Minnie Perlstein, M.D., associate professor of dermatology, University of Illinois College of Medicine, Chicago, periodicals from the library's Clifford G. Grulee collection on pediatrics.

Complex Vitamin Supplements Called Unnecessary to Diet

Deficiency Diseases Are Rare
With Modern Feeding Methods

There is probably little need for complex multi-vitamin preparations to be added to the diet of the healthy pediatric patient. The consumption of natural foods, or carefully processed foods, is the best way to get the required vitamins.

Established methods of infant feeding rarely allows for the occurrence of deficiency disease in children. The majority of infant formulas, if properly prepared, meet the vitamin requirements for infants determined by the Food and Nutrition Board, National Research Council.

Trace quantities of vitamins in foods play an important part in anabolic and catabolic processes. The need for vitamins in various age groups recognizes individual growth patterns. Adequate vitamin D and ascorbic acid is of prime importance during the first two years of life, as is vitamin D, ribroflavin and niacin during the growth spurt of adolescence.

According to published evidence, neither thiamine nor vitamin B_{12} produce a supernormal stimulation of appetite or promotion of growth in children. While thiamine is recognized as essential in body metabolism and vitamin B_{12} has specific medical indications in children as well as adults, neither appears to encourage appetite to the point that increased growth results.

Above: Alfred Dorfman, M.D. (r.), director, La Rabida Sanitarium, Chicago, receives a certificate for the $1,000 E. Mead Johnson award. Edgar E. Martmer, M.D., Detroit, immediate past president of Academy, presented the award to Dr. Dorfman for his studies on the chemical changes that occur in inflamed connective tissue of rheumatic fever patients.

Therapeutic use of vitamins may be indicated in an infant or child with a specific disease, or one whose disease interferes with his food intake or metabolic processes.— **Harry A. Waisman, M.D.,** Department of Pediatrics, University of Wisconsin, Madison.

Scope of Accident Prevention Must Be Broadened

Now 73% of Efforts Directed
Toward Accidental Poisoning

Poison control centers for children in this country have become a familiar pattern. That same pattern must be directed toward other important fields of accident prevention.

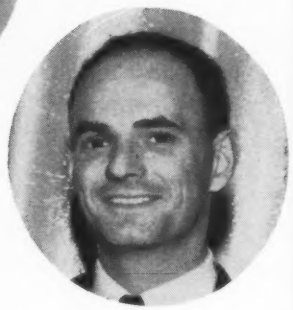
Hospital personnel should be encouraged to initiate prevention activities in the fields of: traffic accidents, drownings, falls and burns.

The attack on accident prevention should not be restricted to four percent of the total accident problem,

(Continued on next page)

Below: Paul B. Franca, M.D. (l.), Mercy Hospital, Sao Paulo, Brazil; Harry Medovy, M.D., professor of pediatrics, University of Manitoba Faculty of Medicine, Winnipeg; and Stanley Levin, M.D., fellow in pediatrics (standing), Sinai Hospital, Baltimore, take notes on the diagnosis and surgical treatment of ventricular septal defects, in exhibit prepared by doctors from the Mayo Clinic, Rochester, Minn.

Above: Denis Browne, F.R.C.S. (r.), senior surgeon, Hospital for Sick Children, London, England, and president, British Association of Pediatric Surgeons, accepts the William E. Ladd medal presented by Edgar Martmer, M.D., Detroit, immediate past president of the Academy, for major contributions to pediatric surgery including new methods of correcting club foot, harelip.



Walter R. Eberlein, M.D. (l.), assistant professor of pediatrics, and Alfred M. Bongiovanni (r.), associate professor of pediatrics, both of University of Pennsylvania School of Medicine, received the $1,000 E. Mead Johnson award for research. The research dealt with studies of disorders that arise when diseased adrenal glands produce large amounts of male sex hormones.

because there is only a four percent return. Preventive programs, broader in scope, and well defined in terms of objectives will be more productive in energy and dollars expanded—and in children's lives saved.

For instance until now about 73 percent of the efforts of the accident prevention committee, American Academy of Pediatrics, have been directed toward reducing accidental poisoning—yet statistics reveal that accidental poisonings cause less than two percent of all accidental deaths among children one to 14 years old.

A survey of the problem of accidents is needed to give a basis for operation. Specific analysis of type, frequency, cause and severity of child accidents—as well as age, sex, and seasonal and regional factors is mandatory.—**George W. Starbuck, M. D.,** Pediatrician in Chief, St. Luke's Hospital, New Bedford, Mass., and Chairman, Committee On Accident Prevention, American Academy of Pediatrics.

Emotions Studied At Massachusetts General

Hospital Personnel Can Substitute for Parents

In the child psychiatry unit of Massachusetts General Hospital, an attempt is being made to prevent, or improve treatment of emotional disturbances associated with illness.

Nurses, doctors and ancilliary personnel are constructive forces within the hospital. They can substitute for parents, and provide an emotional climate freer of tension and overconcern than would exist at home.

The experience of being dependent upon nursing care may be more upsetting to a child than to an adult. The loss of ability to care for himself returns the child to the status of a baby. Resentful the child becomes more infantile in his behavior, and resists nursing care. Nurses should recognize this so that when medically possible they can encourage children to perform their normal routines.

The severity of the illness, the organs involved, the type of treatment and the degree of suffering represent realistic threats to the sick child. Operations and illness activate fantasies of being attacked, mutilated, punished and annihilated.—**Gaston E. Blom, M.D.,** Child Psychiatry Unit, Massachusetts General Hospital, Boston.

National Program Developed To Reduce Newborn Deaths

Conducted Jointly By Six Groups

An information program has been inaugurated to help reduce the high national toll of deaths and brain injuries resulting from asphyxia in newborns.

Infants under one week of age still have a death rate of 18 per 1,000 live births. In contrast, a 50 percent decrease in deaths of babies one to four weeks old has been made.

With proper knowledge of methods for preventing asphyxia and resuscitating an asphyxiated baby many deaths and brain injuries could be avoided. A campaign to carry the information to the nation's 8,000 hospitals, physicians, nurses, residents and students has been started.

The ways of establishing adequate breathing in the newborn will be emphasized first in posters and then in 250,000 follow-up pamphlets. These will be distributed by the American Hospital Association, American Public Health Association and state health departments.

The information program is being conducted jointly by the American Academy of Pediatrics, American College of Obstetrics and Gynecology, American Society of Anesthesiology, American Public Health Association, Academy of General Practice and American Medical Association.—**Wyman C. Cole, Sr., M.D.,** Head, American Academy of Pediatrics, Committee on Fetus and Newborn.

Animal-Borne Parasitic Diseases Increasing in Frequency

Household Pets Can Transmit Serious Infections to Children

The trend toward suburban and exurban residence is encouraging more families to acquire household pets. This may be bringing about an actual rise in the frequency of human parasitic disease contracted from these animals.

Better housing and general sanitation improvements are decreasing the prevalence of human parasitic infections transferred directly from individual to individual. But modern sanitation has had relatively little influence on the habits of household pets.

The control of human-host parasitic diseases in some communities has made animal-borne infections easier to recognize since many of the same symptoms characterize both. At least part of the apparent increase in zoonotic infections among children is attributable to this fact.

Some parasites, particularly some of those found in household pets, can cause serious diseases in children. Others, while less damaging, are readily transmissible to humans. Also, even if a parasite is harmless to human members of the family, it may be harmful to the pet. Hence, parasitic disease, whether it occurs in children or in their animal companions, deserves major consideration.

These hazards do not outweigh the value of owning a household pet, except in special cases. Preventive and therapeutic measures, although not simple, can keep dogs and cats as well as less common household pets free of harmful parasites or at least can minimize the threat to health.—**Paul C. Beaver, Ph.D.**, Department of Tropical Medicine and Public Health, Tulane University School of Medicine, New Orleans, La.

Hospitalization Urged for Child With Severe Bronchial Asthma

Special Rooms Decrease Exposure to Allergens

Hospitalization is urged for children severely ill with bronchial asthma. Change to a hospital not only lessens the inhalation of allergens but also may bring striking improvement by correcting psychological problems, as in removing the child from over-protective parents.

At Chicago Wesley Memorial Hospital, we have 12 special beds for asthmatic patients, equipped with rubber or Dacron pillows and rubber mattresses. These are placed in rooms with air filters in the windows and linoleum-covered floors, which are cleaned with wet mops. In each of the rooms, the chairs are synthetic leather and the curtains light and frequently washed. A sign forbids feathers, flowers and smoking.

Patients allergic to inhalant materials usually recover rapidly in such rooms, a fact which helps determine the cause of the attack. If asthma does not lessen in two or three days, search must be made for other causes such as food allergy, an infectious process, a psychogenic influence or a foreign body.

The allergens responsible for bronchial asthma in children are easily detected in about 95 percent of patients. In children of allergic parents, preventive measures can delay the onset and lessen the severity of allergic conditions, including asthma.

Best results are obtained by strict avoidance of causative allergens and by hyposensitization with important inhalant materials. Skin tests should be made in all patients with all protein-containing materials to which the child is exposed.—**Leon Unger, M.D.**, and **James H. Johnson, M.D.**, Northwestern University Medical School and Chicago Wesley Memorial Hospital, Chicago; **A. Alvin Wolfe, M.D.**, University of Illinois School of Medicine and Michael Reese Hospital, Chicago; and **Donald L. Unger, M.D.** Mount Sinai Hospital, Chicago.

Broad Range of Host Animals May Transmit Leptospirosis

Appreciable Increase In Human Cases

Statistics show an appreciable increase in human cases of leptospirosis in the United States since 1948. The disease constitutes a major problem in cattle and swine

The leptospiroses are actually a group of diseases, caused by a variety of serotypes. For many years, rats and dogs were thought to be the primary carriers, but research has proven that a number of domestic and wild animals may act as carriers, transmitting infection to other animals and to man.

Transmission can occur by direct contact with infected urine, or with tissues of infected animals, or by indirect contact with contaminated water. The mucous membranes or abraded skin are usual entry portals.

Outbreaks have occurred in the U.S. and most other parts of the world as a result of people swimming in contaminated water. These outbreaks usually come during late summer and involve adolescents or young adults primarily.

Sporadic cases arise among workers whose occupations bring them in contact with diseased animals or infected areas. The disease is rare in children, the few cases that occur usually arising from contact with a domestic animal pet.—**James H. Steele, D.V.M.**, Department of Health, Education, and Welfare, Public Health Service, Bureau of State Services, Communicable Disease Center, Atlanta, Ga.

NEW
40% Nebulizer

A new nebulizer is available for Armstrong Baby Incubators. It has a 40% Oxygen Limiting Device — or may be instantly changed to a full flow of oxygen — as you wish. Either way it gives a generous fine fog. Cleans easily. Send for free information.

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Nurse Wins Confidence With Animal Cards

Tiny animal pictures printed on insert cards sealed inside Ident-A-Band* on-the-wrist identification bracelets are giving small children a pleasant introduction to their hospital visits.

The child's name and hospital number and the doctor's name are filled in on the cards next to the picture. The child can make his own choice of animals—chick, puppy, horse, cat or duck.

After the identification card is inserted in the soft plastic band and sealed around the wrist, the animal appears upside down to the nurse but right side up to the child.

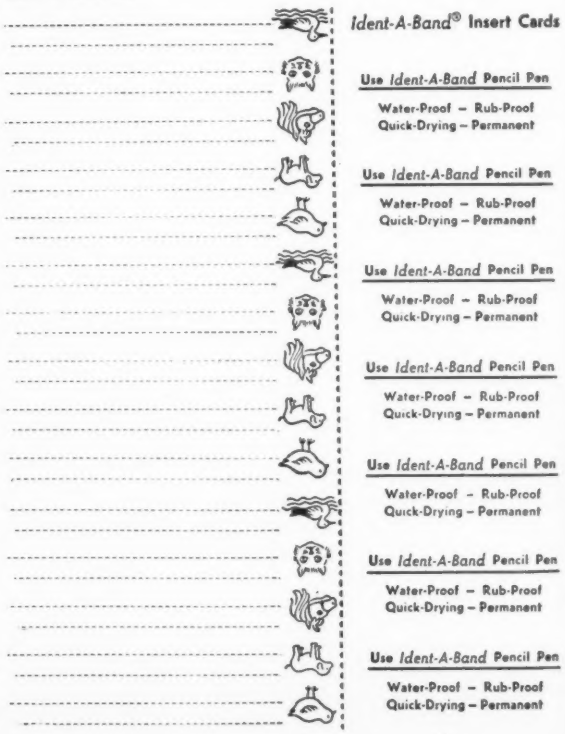
These small animal pictures help relieve the child's nervousness in an unfamilar surrounding. They also create a conversation piece for the nurse and the child. Before an operation, they distract the child's attention, giving him something known and happy to think about.

Ident-A-Bands without animal insert cards are available for adult and OB patients.

*Manufactured by Franklin C. Hollister Co., Chicago.

Above: Animal pictures printed on the cards help nurses and attendants win the confidence of the small child. By "breaking the ice," cards secure child's co-operation and affection.

Below: Animal insert cards are book-bound and perforated for easy removal after data is typed or written in. The animals are "down side up" so the animal will be facing the child when the card is inserted.



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Leading Hospitals **insist on FENGEL SUPERIOR SURGICAL NEEDLES because:**

FENGEL NEEDLES are made in REDDITCH, ENGLAND the *Needle Capital of the World.*

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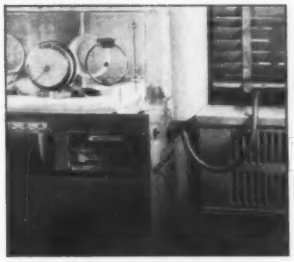
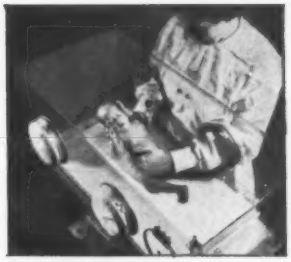
When you choose an infant incubator, consider



1. True Isolation: Only the ISOLETTE® continuously draws in fresh, pathogen-free air from outside the nursery, forces out used air, protects the infant from air-borne or droplet infection. The ISOLETTE completely replaces incubator air every 15 minutes, approximately.

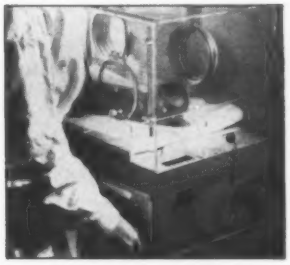


2. Constant Circulation of Fresh, Warm Air: The ISOLETTE alone provides a continuous supply of clean, fresh air, with precise control of warmth, humidity, and extra oxygen (when needed)—features impossible to achieve without controlled, mechanical air circulation.

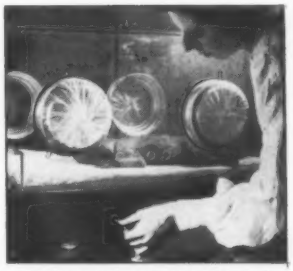
4 facts of life

In incubator care of **the small premature infant . . .**

. . . the ill premature infant . . . the infant requiring isolation



3. Precise Temperature Control: Within a tolerance of 1°F., plus an automatic alarm should external factors cause overheating, is another unique advantage of the ISOLETTE, which may also be cooled to 85°F. in very hot weather.



4. Accurate Humidity Regulation: An additional, exclusive distinction of the ISOLETTE, maintains even, optimal humidity levels (85% to 100%) by means of a simple, calibrated valve, and quite independent of temperature.

The ISOLETTE, only "completely air-conditioned" infant incubator described and illustrated in the new 2nd edition of "*Premature Infants*," may serve also as "an isolation unit in addition to maintaining optimal environmental conditions, and is particularly useful in caring for the smallest infants."*

Many infant incubators now look like the ISOLETTE, but sell for less. Therefore, we recently engaged a well-known, independent laboratory to compare control of temperature, humidity, and oxygen in every infant incubator on the market. We'll be glad to mail you the 22-page report of this objective comparison study. Or you can make your own tests of ISOLETTE performance with any other incubators. If you're not satisfied in 30 days, return the ISOLETTE to us, express collect, and discard your invoice.

For value, choose the ISOLETTE. It is designed to perform, built to last. We have never had to replace a worn-out ISOLETTE. Phone us collect (OSborne 5-5200, Hatboro, Pa.) and order an ISOLETTE with our 30-day return privilege. Test it. Pay only if satisfied. But don't let appearance or initial cost mislead you: let *performance* guide your choice.

The Isolette®

Constant-fresh-air-flow infant incubator

first in its field . . . widely copied . . . never equalled

Designed, Manufactured, Sold and Serviced by **AIR-SHIELDS, INC.** *Hatboro, Pa.*

*Dunham, E.C.: *Premature Infants*, 2nd Ed., Hoeber-Harper, New York, 1955

Throughout the hospital there are more and more calls for

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highly soluble, single sulfonamide

Respiratory Infections	tablets, 0.5 Gm each
Meningitis Surgery	ampuls, 5 cc (2 Gm) and 10 cc (4 Gm)
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Pediatrics	pediatric suspension (raspberry-flavored), and syrup (chocolate-flavored), containing the new, tasteless Gantrisin (acetyl)
Eye, Ear, Nose & Throat Infections	ophthalmic solution, 4%, ophthalmic ointment, 4%, ear solution, 4%, and nasal solution, 4%
Obstetrics & Gynecology	vaginal cream, 10%, in white vanishing cream base
Outpatient Clinic	tablets, 0.5 Gm each

Gantrisin®—brand of sulfisoxazole
Gantrisin® (acetyl)—brand of acetyl sulfisoxazole

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Student Help Eases Shortage at Silver Cross

• Silver Cross Hospital, Joliet, Ill., is easing its shortage of laboratory personnel with a concentrated program of student aid. In 1956, the hospital had eight technologists, but needed 14—however, technologists just weren't available. Contact was made with Joliet Junior College to find students interested in technology as a career. Six students helped out in the Silver Cross laboratory doing routine tasks. They were paid on an hourly basis.

In this manner the students were able to find out if they really wanted to be technologists. And, at the same time, they were helping to relieve the shortage in the laboratory, according to B. H. Neiman, M.D., director of laboratories.

After their spring vacation this group continued to work on Saturdays. One student worked from 4 p.m. until 8 p.m. every night of the week. Then, when summer vacation arrived the six students came back to Silver Cross full-time.

Last summer, three additional students were added, making a total of nine. Each student is under the direction of a technologist.

The first step in the training is under the direction of a laboratory aide who teaches the student how to locate different pieces of glass, how to wash glassware properly, and how to store glassware.

During their full-time summer work, the students collect blood by venipuncture, do a blood count and perform the simpler tests, such as blood sugar, blood urea and nitrogen and creatinine.

Students, under direction, spend at least a month learning to identify the formed elements in urine sediment for urinalysis. The chemical part of the urinalysis can be learned in a short period of time. It is practice that is important, according to Bernadine Boecker, chief medical technologist, and practice is what the students get at Silver Cross.

Students are not able to do the more specialized tests because they do not have enough theoretical background. Because Silver Cross does not operate a school of medical technology the students must serve their formal internship elsewhere.

After the students have learned how to obtain information from tests, they must learn to record it since, as Miss Boecker points out, there is little use in doing an accurate test if the information is recorded incorrectly. Thus, the students next move to the office where they learn how to record what they have found.

This year Silver Cross is hoping to incorporate, in the students' training program, instruction on the inoculation of media with material sent to the lab by physicians and the identification of organisms in the resulting culture.

(Continued on next page)

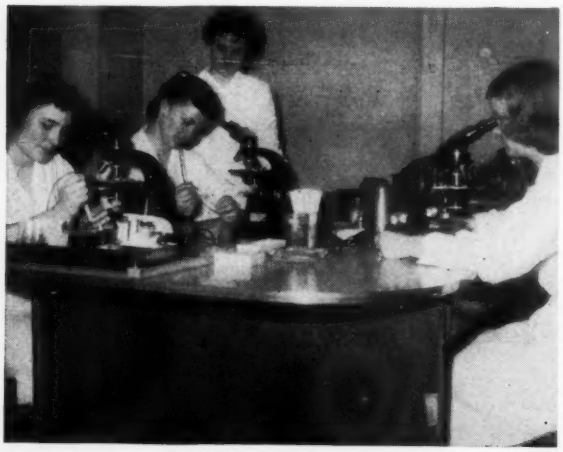
Left: Ann Wisdom, student, watches Pat Sohan, M.T., pipetting a filtrate.

Right: Bernadine Boecker, chief technologist, illustrates a point for Jean Uhde.

Above: Pat Planke gives a venipuncture to her instructor, Eloise Gerlich, M.T.

One student interested in going to medical school, is helping with autopsies. He assists the pathologist and cleans the laboratory after the autopsy. In this way he is obtaining valuable knowledge and insight before entering medical school.

The laboratory tries to hire the high school graduate during summer vacation. Then this same student, during the summer after the first year of junior college, and possibly the following summer, can return to work at Silver Cross. Then, after taking the one-year internship, according to Miss Boecker, it is hoped that the student will come back to work as a full-time medical technologist at Silver Cross.



Above: Janet Barber, M.T., watches Beth Wisdom and Karen Johnson, left side of table, set up a blood count. Across the table Jean Uhde is making a count.

Above: Helen Mizicko, aide, shows Maurine Foote, a student from the junior college, how important it is to keep the laboratory glassware absolutely clean.

Right: Beverly Hacke takes a message over the phone to pick up an order from the pediatric department and gives it to Ann Wisdom, who acts in a messenger capacity.

Above: Betty La Schiazza, M.T., shows Al Patten pertinent points to watch for in examining a culture. She also shows him how to inoculate media. Mr. Patten is a student interested in entering medical school. He also helps with autopsies.

Above: Bernadine Boecker, chief technologist, shows Beth Wisdom how to read photometer for hemoglobin determination.

keeping tab on the lab

By Marlene Burgess*

● During October and November in Georgia the state health department is presenting a series of clinical laboratory institutes. Anyone who is interested in planning similar programs for his area might like to know how it is done in our state.

First of all, the hospital laboratories over the state are sent questionnaires so that the technicians can name the exact subjects which they wish presented in their area. The majority rules, of course, but every effort is made to present the subjects which are most requested. Meeting places and instructors are engaged; brochures on the meetings are sent to every laboratory in the state. The technicians come, and we feel that everyone, instructors included, goes away with new and helpful information.

*Laboratory consultant, Division of Hospital Services, Georgia Department of Public Health, Atlanta.

In October three meetings were presented in various areas of the state, on the subject of enteric bacteriology. Salmonellae and shigellae were discussed chiefly, along with methods for differentiating these organisms. Biochemical tests for differentiation were demonstrated and discussed. Concern was only with the pathogenic enteric bacilli.

Booklets are made to accompany the lectures at all the institutes. An excellent method of teaching the many and varied reactions involving color is to actually color the reactions on paper as they occur for the students. On the printed page it is extremely difficult to reproduce true color reactions, but someone who is familiar with the colors and sees them daily can, with the help of crayons, reproduce them well. Medical technology instructors would find this method advantageous in teaching laboratory students.

In November two meetings are planned with more diverse subjects. The day's instruction will include brief mention of laboratory safety and a copy of Fisher's new "Manual of Laboratory Safety." About an hour will be given to prothrombins. Many problems occur periodically in the prothrombin department. In the writer's experience, almost all of these problems result from not following directions for the test carefully and/or unclean glassware.

A few minutes of the program will be on acid-fast staining technics. Although many persons do not take time to make good acid-fast stains, usually the problems occur in this procedure because of failure to select the best portion of the specimen for staining or failure to examine the smear thoroughly.

The C-reactive protein test will be demonstrated, since everyone seems to be interested in this test.

The remaining portion of the day will be allotted to a discussion of red blood-cell morphology and hemoglobin determinations. Laboratories become so well acquainted with the blood smear that its importance is frequently overlooked. If the physician had to choose one hematological test, the differential would probably be the chosen one. It is this good only when the technician is making comments on cell morphology, number of platelets, and the like.

Toy Train Protects Personnel from Radiation

● A toy train is reducing the hazards of handling radioactive materials at the Cleveland Clinic.

At the flick of a switch, the locomotive moves, drawing a flat car equipped with six round lead sockets. These sockets hold the cargo.

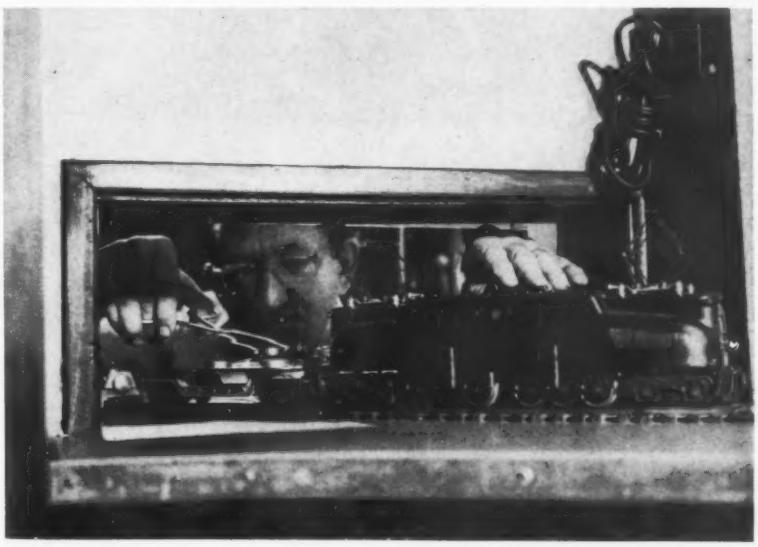
When first put into use, the train handled only radon, a radioactive gas, drawn from the basic supply of radium in the clinic laboratory. Technicians sealed the gas in tiny glass tubes which, in turn, were placed in platinum containers and mounted on the flat car.

Today, liquid radioactive gold, solid radioactive iodine and phosphorus, and other materials are carried by the train.

When radioactive substances must be tested, the train carries them to the measuring instrument, where the strength and penetration of their various radiations can be calibrated. Using the train reduces the danger to personnel from radiation.

After being measured the substances are used for the treatment of disease or for medical research carried on at the clinic.

Radioactive substances are stored in small containers in a room off the main laboratory. Lead bricks frame the section. A brass crane with a movable arm is used to place the containers on the train and remove them.



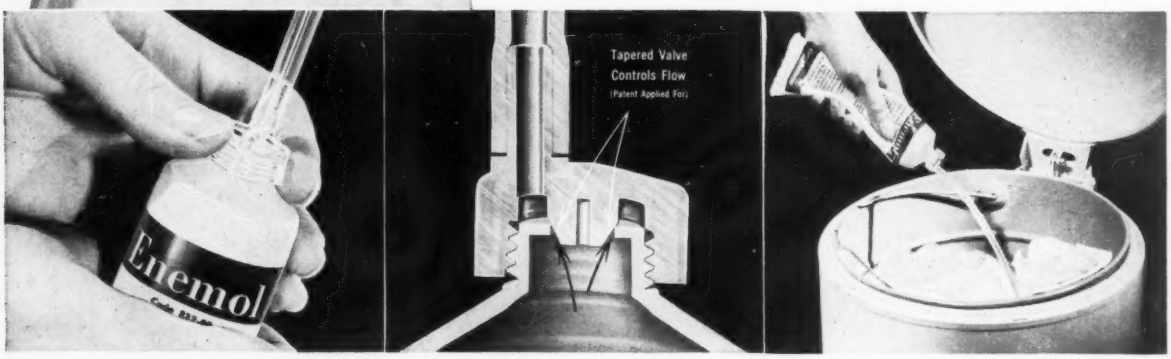
"Enemol makes giving enemas an easier chore"

It used to be that preparing and giving those routine enemas topped my list of "Most Unpleasant Nursing Chores." But, with Enemol — it's so much easier and faster that I don't mind it nearly as much.

The thing I like best about **Enemol*** is that there's no equipment to assemble or solutions to mix. Better yet, there's no messy equipment to clean up afterwards because you just throw the used container away. That means as much as 20 minutes saved — to spend doing something else.

Enemol ***is the only disposable enema*** I know of, with a shut-off valve you can easily open and close with a simple twist. You can even clear air from the tube before inserting. The tube, with its soft round top, is just stiff and long enough (6 inches) to insert easily without hurting the patient.

Having an enema is never pleasant, but Enemol makes it a lot less uncomfortable for the patient to take. That's because there are only 4½ ounces of fluid instead of the usual quart. And for routine enemas, this time-proven phosphate solution really does a better job than soap suds.



Enemol disposable Enema Unit

- *Saves nursing time*
- *Reduces expense*
- *Increases patient comfort*

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Packed in easy-to-handle cases of 24; 4½ oz. units.

60th *fine pharmaceuticals for 60 years*

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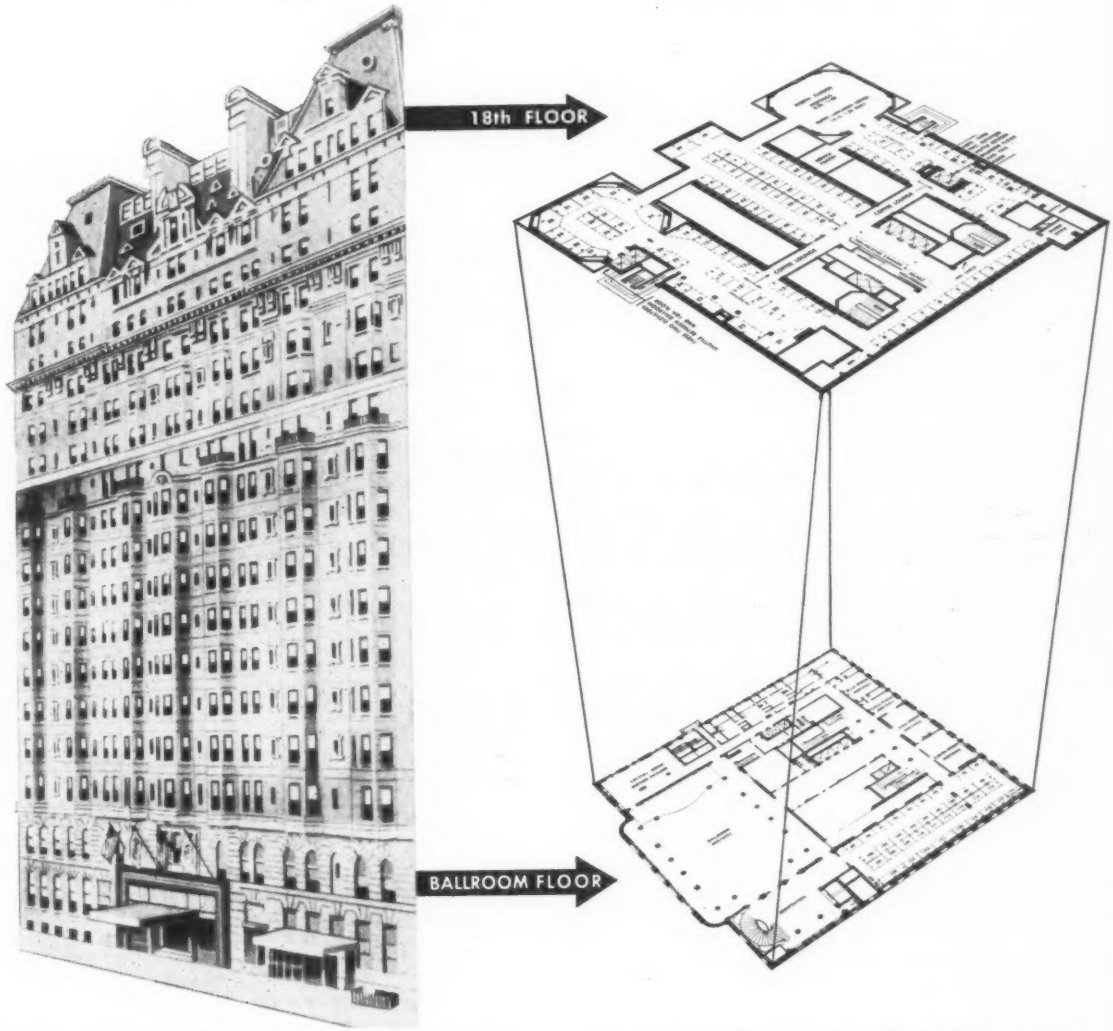
BERKELEY, CALIFORNIA

HOSPITAL Topics OR

Official bulletin for the
Association of Operating Room Nurses

All Eyes Are on Philadelphia



PHILADELPHIA, one of the nation's leading medical centers, is currently the focal point of interest for operating room nurses, because it is the site of the fifth national congress of the Association of Operating Room Nurses, February 10-13, 1958.

Above is the headquarters hotel for the meeting—the Bellevue Stratford. The diagram at right shows the two floors on which all meetings and exhibits will be held. For larger diagrams of these floors, see pages 106 and 107.

See advance program on pages 101-103.

Factors to Consider in Planning Student's O. R. Experience

By Col. Agnes A. Maley, ANC*

● Operating-room nursing in the Army Medical Service is considered a nursing specialty that requires additional preparation beyond the basic nursing program. However, the problems of basic operating-room nursing education are universal.

There is a diversity of opinion regarding the length of time and the placement of operating-room experience in the total curriculum. In relation to the amount of time that students should spend in the operating room, many factors must be considered.

The operating room is one of many departments within the hospital in which nursing care is rendered. Because nursing care in the operating room is a special kind not usually given in nursing units and other departments of the hospital, the nursing curricula must include principles of operating-room nursing to develop the attitude that surgical intervention for correction of a diseased condition is but one step in the continuity of patient care.

Review of the literature on the subject indicates that nursing educators as well as students believe that a minimum of eight weeks is necessary. However, one school believed it attained its objectives in four weeks. This was accomplished by planning for the operating-room experience to contribute to the over-all objectives of the medical-surgical experience as well as those of the entire program.

DIRECTED EXPERIENCE NECESSARY

The amount of time a student spends in the operating room is not as important as the way in which her time is spent. Advances in medical practice have brought about the need to extend both theory and directed learning experience throughout the entire curriculum. When we consider the time that should be spent in any one unit, we must keep in mind that the primary purpose of basic nursing education is to prepare qualified persons for the practice of nursing. Therefore, basic students should, I believe, have only the directed clinical experiences that will enable them to have an understanding of the total nursing care of the patient.

Many factors will influence the time spent in the operating room to accomplish this. The relationship between operating-room supervisor, staff nurses, and clinical instructor would be a determining factor. If the operating-room staff feels a responsibility in guiding the students through meaningful learning experiences, the students will learn quickly. On the other hand, if the staff is overworked or is not prepared for this responsibility, the students may have limited learning experiences.

Also, the individual differences of students require that consideration be given to adjustment in clinical experience. Another consideration is the number of students receiving clinical experience in the operating room at any one time.

Thus, it is difficult to set a "time-table" on clinical experience in the operating room because the school environment varies from school to school. However, it appears that, to meet the objectives of the medical-surgical unit, clinical experience may be extended from four to eight weeks. Somewhere in between may be the answer.

Objectives of this experience should be as follows:

1. To learn the principles of aseptic technic and application of these principles in operating-room nursing, surgical nursing, pediatric, obstetric, public health, clinic and medical nursing.

2. To learn the functions of operating-room nursing care.

3. To gain an understanding of the terminology of operative procedures.

4. To gain an insight of the relationships of pre and postoperative nursing care, especially with regard to the anesthetic agents used, the physical manipulation of the body or part thereof, and the physical and emotional needs of the patient as a result of the operative procedures.

5. To help the student function successfully as a team member in the operating room.

These general objectives are not all-inclusive, but should be an integral part of the objectives of the medical-surgical unit.

It would appear that the primary factor to be considered in providing operating-room experience for the basic student program today is that such experience should be an *integral* part of the student's total knowledge and understanding of nursing. This experience must be looked upon as being primarily an orientation phase, not one which prepares the student nurse to function as an effective operating-room nurse upon completion of her basic program.

The responsibilities of the professional nurse in military operating-room nursing may be greater than those

*Colonel Maley is chief nurse, medical section, Sixth Army Area Headquarters, San Francisco. This article is adapted from a paper presented at the fourth national congress, Association of Operating Room Nurses, Los Angeles, February 18-21, 1957.

of the civilian operating-room nurse. Obesrvations of very active Army operating rooms have indicated that the ratio of professional to nonprofessional nursing service personnel is usually one to two. This means that the military operating-room nurse carries a tremendous responsibility for the teaching and supervision of these young nonprofessionals giving nursing care, in addition to carrying out her own complex nursing functions. Obviously, she must be well trained and skilled, and must have developed an insight into the problems of operating-room nursing. She is expected to function effectively as a member of the surgical team.

The Army operating-room nurse rotates from hospitals in the United States to overseas hospitals. Most overseas tours of duty are for two-year periods. If the nurse is assigned to one of the large Army hospitals in the United States as a staff operating-room nurse, her role is comparable to that of a staff operating-room nurse in a large civilian hospital, but if she is assigned to a small hospital or field unit, she may be the only operating-room nurse.

Therefore, in addition to having an understanding of the principles of operative aseptic technic, operative procedures, methods of sterilization, and preoperative and postoperative care, she must be prepared in the principles of administration and teaching. In other words, she may find herself in a situation in which she must set up an operating room with only the assistance of enlisted personnel who may not have had previous operating-room preparation or experience.

Seldom is it necessary to assign an inexperienced operating-room nurse to such a situation during peacetime, but there is always the possibility of a national emergency, and operating-room nurses must be prepared for it. To accomplish this, the Army Medical Service has established two courses in operating-room nursing and administration. The role of the Army operating-room nurse is implicit in the objectives of these courses, which are:

1. To enrich the student's understanding of what illness means to a patient physically, psychologically, and spiritually, and what the socioeconomic factors are.

2. To develop the attitude that surgical intervention for correction of a diseased condition is but one step in the continuity of patient care.

3. To learn principles and methods of sterilization and to develop skills in these methods in order to provide safe patient care.

4. To learn the value of interdepartmental and intradepartmental relationships and to recognize contributions other departments make to total patient care.

5. To develop a better understanding of the operative procedures in the various surgical specialties through concurrent theoretical classes and directed clinical activities disciplined by scientific methods.

6. To develop an understanding and an appreciation of the principles of administration and teaching.

7. To gain a better appreciation and understanding of team concept in total care of the patient.

8. To develop an understanding of the role of the operating-room nurse in an emergency situation, disaster, combat areas and mass casualties.

9. To develop an awareness of the vast area of research open to operating-room nurses.

10. To gain a better understanding of the physical standards of an operating room in order to provide safe patient care.

11. To gain an understanding of the function of the central materiel section and its great contribution of indirect operative care of patients.

12. To increase understanding of operating-room nursing and administration in as many facets as possible.

13. To gain a better appreciation of surgical instruments and equipment, their use, source of supply, maintenance, and cost.

The 22-weeks' course conducted at Walter Reed Army Hospital, Washington, D. C., uses the following methods to accomplish these objectives:

1. Selected learning activities in clinical experience in the surgical specialty areas, 360 hours.

2. Projects.
   a. Comprehensive surgical care study
      (1) Medical and nursing care plan
      (2) Total patient care (physical, psychological, and socioeconomic)
   b. Paper to be written about one phase of operating-room nursing or closely related subject.

The students are given one week (25 hours) of directed experience in operating-room administration and two weeks (50 hours) in operating-room clinical instruction. They are enrolled at the Catholic University of America for courses in "Principles of Learning and Teaching," "Principles of Management," and "Principles and Methods of Supervision."

COURSE CURRICULUM REVISED

In 1956 the course curriculum was revised to include: nursing care of mass casualties, 20 hours; medical supply, four hours; cardiac arrest, two hours; operating-room nurse's role in relation to anesthesia, two hours; methods of instruction, two hours; positioning, two hours; and the spiritual needs of patients, two hours (the last conducted by chaplains of three faiths—Protestant, Jewish, and Catholic).

This course has been successful in preparing operating-room nurses to function effectively as a member of the Army surgical team in meeting the mission of the Army Medical Service wherever she may be assigned.

Army nurses who have not had previous civilian postgraduate courses and are interested in operating-room nursing may apply for these courses after they have had one year's experience in Army nursing. Selection is based upon the individual's performance, interest, and the recommendations of her chief nurse. Generally, it has been our experience that nurses who are competent medical-surgical nurses with ability to function as the leader of a nursing-care team are successful in completing the course and become competent operating-room nurses.

Army nurses are graduates from three-, four-, and five-year accredited schools of nursing, and they have varied backgrounds and experiences. Regardless of how much time a young graduate spent in the operating room during her basic preparation, she should have specific preparation and directed experience to enable her to function as an Army operating-room nurse. This, we believe, can be accomplished through courses such as the one discussed.

Portable Instrument Rack Saves Sorting Time

● An instrument storage rack designed and developed at the Cottage Hospital, Santa Barbara, Calif., can be taken directly into the clean-up area, so that instruments are sorted and stored as soon as they are cleaned and dried, thus eliminating a second handling.

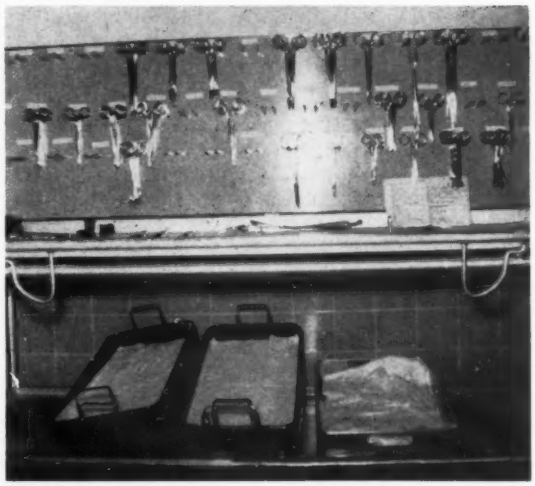
A formica-covered board six feet long, 20 inches wide, and one-half inch thick is fitted with three rows of pairs of labeled 3½-inch metal pegs covered with rubber sheaths to prevent slipping of the instruments.

The first row accommodates the longest forceps. Seven inches below this, a second row holds instruments of intermediate size. A third row, four inches below the second, holds the smallest instruments.

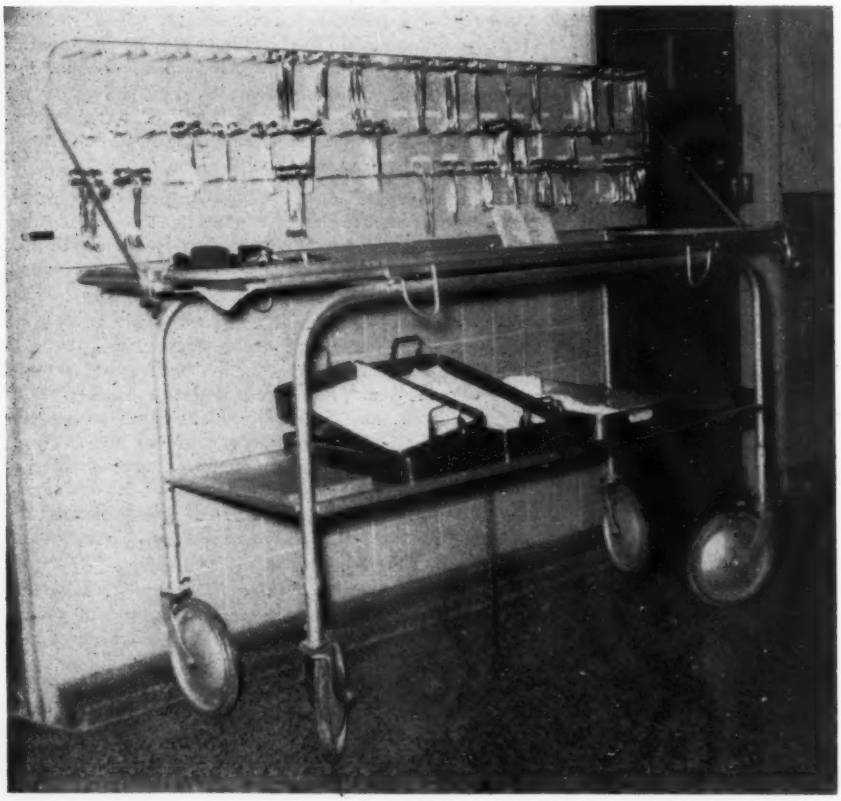
The rack is portable. It can be hung on a wall in the clean-up room and then moved to a wall in the storage area, or it can be fastened to an old stretcher cart.

Formerly instruments were stacked on trays after terminal sterilization and cleaning, until time was found for sorting. With the present system of prompt sorting, it is estimated that 75 percent of the time originally spent on this chore is saved.

Lila Gary, O.R.S., says that the operating-room staff will be glad to answer any questions on the rack and would like to hear from other surgery departments which may put the idea to use.



Above: A close-up of the rack, fastened to an old stretcher cart. It also can be hung on a wall.



At left: Full view of stretcher cart with instrument rack attached. Board could be painted instead of being covered with formica, but hospital personnel find that formica covering prevents scratching and marring which would result if board were painted.

For a story of interest to every O.R. nurse—on electron-beam sterilization of sutures—see pages 22-25.

Fifth National Congress

ASSOCIATION OF OPERATING ROOM NURSES

Philadelphia, Pennsylvania

February 10-13, 1958

MONDAY, FEBRUARY 10

Morning Sessions

7:30 a.m. **Registration**

8:30-11:00 ***North Garden***

8:30- 9:30 **Plastic Surgery**
John D. Reese, M.D., Clinical Professor of Plastic and Reconstructive Surgery, Jefferson Medical College, Philadelphia

9:45-11:00 **Radium and Radioisotopes**
(A discussion on safeguards in handling, transporting, and storing these materials, and on policies and standards applying to O.R. personnel who work with radioactive elements)
Millard N. Croll, M.D., Associate Professor of Radiology, Hahnemann Medical College and Hospital, Philadelphia

8:30-11:00 ***Burgundy Room***

8:30- 9:30 **Blood-Vessel Surgery**
(A discussion of the indications for surgery on blood vessels, including the methods of repair and the various materials available for grafting)
Julian Johnson, M.D., Professor of Surgery, University of Pennsylvania School of Medicine, Philadelphia

9:30-11:00 **Panel Discussion: Housekeeping and the Operating Room**
Moderator: John G. Steinle, Hospital Consultant, Garden City, N.Y.
Participants:
Harry A. Stroh, Consultant, Housekeeping, Inc., New York City
John T. Gondolfo, Senior Methods Analyst, Institutional Products Division, General Foods Corp., White Plains, N.Y.
Frank J. Sullivan, Consulting Engineer (specializing in hospitals), New York City
O.R. NURSE—to be announced
HOSPITAL HOUSEKEEPER—to be announced

8:30-11:00 ***Ballroom***

Sterilization Symposium
Moderator: John C. Gabel, Manager, Hospital Sterilizer and Light Sales, Wilmot Castle Co., Rochester, N. Y.
Participants:
Velma L. Chandler, Ph.D., Chief, Department of Microbiology, Ethicon, Inc., Somerville, N.J.
Earle H. Spaulding, Ph.D., Professor of Microbiology, Temple University School of Medicine, Philadelphia
Robert C. Bogash, Director, Pharmacy Department, Lenox Hill Hospital, New York City
Vernita Cantlin, R.N., Formerly Operating Room Supervisor, Graduate Hospital of the University of Pennsylvania, Philadelphia (now completing work for master's degree at the University of Pennsylvania)
Muriel L. Walton, R.N., Supervisor, Central Service Department, Roosevelt Hospital, New York City
Others to be announced

Afternoon Session

2:30- 5:30 p.m. ***Ballroom***

2:30- 2:40 **Address of Welcome**
Isidor S. Ravdin, M.D., John Rhea Barton Professor of Surgery, University of Pennsyivania School of Medicine, Philadelphia

2:40- 3:00 **AORN Business and Delegates' Meeting**

3:00- 5:30 **Panel Discussion: Improving Operating-Room Work Relations Through Communication—Leadership—Human Understanding**
Participants:
J. Thomas Freeston, Personnel Director
Earl G. Planty, Ph.D., Professor of Management, University of Illinois, Urbana
Others to be announced

TUESDAY, FEBRUARY 11

Morning Sessions

8:30-11:00 a.m. ***North Garden***

Panel Discussion: Planning and Designing the New Operating Room
Isadore Rosenfield, Architect, New York City

8:30-11:00 ***Burgundy Room***

8:30- 9:45 **New Trends in Laryngology and Broncho-Esophagology**
Chevalier L. Jackson, Jr., M.D., Professor of Laryngology and Broncho-Esophagology, Temple University School of Medicine, Philadelphia

10:00-11:00 **The Artificial Kidney**
Lewis W. Bluemle, Jr., M.D., Assistant Professor of Medicine, University of Pennsylvania School of Medicine, Philadelphia

8:30-11:00 ***Ballroom***

8:30- 9:30 **New Trends in Cardiovascular Surgery**
Charles P. Bailey, M.D., Professor of Thoracic Surgery, Hahnemann Medical College and Hospital, Philadelphia

9:45-11:00 **Recovery and Postanesthesia Units**
(A discussion of the postanesthetic care of patients including methods of resuscitation and cardiac arrest)
Robert D. Dripps, Jr., M.D., Professor of Anesthesiology, University of Pennsylvania School of Medicine, Philadelphia

Afternoon Session

3:00- 5:00 p.m. ***Ballroom***

Panel Discussion: Hospital Infections Due to Antibiotic-Resistant Staphylococci: Bacteriological and Clinical Experiences and Methods of Control
H. Taylor Caswell, M.D., Clinical Professor of Surgery, Temple University School of Medicine, Philadelphia, and the following discussants, all from Temple University School of Medicine and Hospital:
Kenneth M. Schreck, M.D., Assistant Professor of Microbiology
Elsie R. Carrington, M.D., Assistant Professor of Obstetrics and Gynecology
Norman Learner, M.D., Associate Professor of Internal Medicine
Howard H. Steel, M.D., Assistant Professor of Orthopedics
R. Robert Tyson, M.D., Assistant Professor of Surgery
Florence E. Brown, R.N., Director of Nurses
Mildred L. Guzara, R.N., Operating Room Supervisor
(A scientific exhibit on this subject will also be displayed during the Congress)

WEDNESDAY, FEBRUARY 12

Morning Sessions

8:30-11:00 a.m. ***North Garden***

8:30- 9:45 **Panel Discussion: Changing Patterns in Operating-Room Staffing**
Participants:
TECHNICAL AIDE PROGRAM IN GOVERNMENT HOSPITAL—Capt. Marian Rolfe, Instructor, Operating Room, Valley Forge Army Hospital, Phoenixville, Pa.
TECHNICAL AIDE PROGRAM IN CIVILIAN HOSPITAL—Speaker to be announced
PRACTICAL NURSE PROGRAM—Mary Ellen Yeager, R.N., Operating Room Supervisor, Elmhurst (N.Y.) Hospital

10:00-11:00 **How to Develop Visual Aids**
Speaker to be announced

8:30-11:00 ***Burgundy Room***

8:30- 9:30 **Analysis of Present-Day Technics for Long-Term Decompression of Increased Intracranial Pressure**
(Use of the Holter valve in treatment of hydrocephalus)
Eugene B. Spitz, M.D., Assistant Professor of Pediatric Neurosurgery, University of Pennsylvania School of Medicine, Philadelphia

9:45-11:00 **Successful Severance of Siamese Twins**
Bertram Katz, M.D., Youngstown, O.

8:30-11:00 ***Ballroom***

Fire in the Operating Room
Speaker to be announced

Among the AORN Speakers . . .

Shown at right are six of the many prominent speakers scheduled to appear on the program of the fifth AORN congress. In top row (l. to r.) are three members of the panel which will discuss hospital infections due to antibiotic-resistant staphylococci: Kenneth M. Schreck, M.D., assistant professor of microbiology; Florence E. Brown, R.N., director of nurses; and Elsie R. Carrington, M.D., assistant professor of obstetrics and gynecology, all from the Temple University School of Medicine and Hospital, Philadelphia.

In the second row are (l. to r.): Mildred L. Guzara, R.N., operating room supervisor, Temple University Hospital, who will also appear on the panel on antibiotics; Frank J. Sullivan, consulting engineer, New York City, who will participate in a discussion on housekeeping and the operating room; and Charles P. Bailey, M.D., professor of thoracic surgery, Hahnemann Medical College and Hospital, Philadelphia, who will talk on "New Trends in Cardiovascular Surgery."

Dr. Schreck

Miss Brown

Dr. Carrington

Miss Guzara

Mr. Sullivan

Dr. Bailey

Afternoon Sessions

3:00- 5:00 p.m. ***North Garden***

Problem Clinic for Small Hospitals (15 to 75 beds)
Moderator: Elsie B. Cantwell, R.N., Executive Secretary, Bucks-Philadelphia Area, Pennsylvania State Nurses' Association

Participants:
SURGEON—John T. Murphy, M.D., Scranton, Pa.
ADMINISTRATOR—to be announced
ANESTHESIOLOGIST—Lewis C. Hitchner, Jr., M.D., Crozer Hospital, Chester, Pa.
DIRECTOR OF NURSES—Ruth Smith, R.N., Delaware County Hospital, Drexel Hill, Pa.
OPERATING ROOM SUPERVISOR—Mrs. Julia Boyle, R.N., Oxford Hospital, Philadelphia
Questions from the audience

3:00- 5:00 ***Ballroom***

Problem Clinic for Average and Large Hospitals
Moderator: Theresa I. Lynch, Dean, School of Nursing, University of Pennsylvania Hospital, Philadelphia

Participants:
SURGEON—Lewis Kraeer Ferguson, M.D., Professor of Surgery, Woman's Medical College of Pennsylvania and University of Graduate School of Medicine
ADMINISTRATOR—Charles Paxson, Hahnemann Medical College and Hospital, Philadelphia
ANESTHESIOLOGIST—Edward T. Lawless, M.D., St. Joseph's Hospital, Paterson, N.J.
DIRECTOR OF NURSES (GOVERNMENT HOSPITAL)—Dorothea Hufcut, R.N., VA Hospital, Wilmington, Del.
DIRECTOR OF NURSES (CIVILIAN HOSPITAL)—Mary Jane Venger, R.N., Albert Einstein Medical Center, Philadelphia
OPERATING ROOM SUPERVISOR—Sister Mary Albina, R.N., Agnes Hospital, Philadelphia
CLINICAL INSTRUCTOR—Lillian Sholtis Brunner, R.N., Bryn Mawr, (Pa.) Hospital
Questions from the audience

THURSDAY, FEBRUARY 13

The day immediately following Congress sessions has again been designated as "AORN Hospital Day." Plans are under way for special programs to be given in Philadelphia hospitals, and also for several tours of manufacturing plants in the area. Details will be announced in a later issue of HOSPITAL TOPICS.

OR QUESTION BOX

BY CARL W. WALTER, M.D.

Assisted by Dorothy W. Errera, R.N.

Q. Will ethylene-oxide sterilization ever replace steam sterilization?

A. Ethylene-oxide sterilization is valuable for sterilization of heat-sensitive materials, such as certain plastics, shoes, clothing, and mattresses, but the time required for sterilization makes it impractical for universal, over-all use in surgery. At 140° F. the exposure time is four hours; at 120° F. the time is six hours.

In sterilizing items such as powders, mattresses, blankets, telescopic instruments, and the like, time is a minor factor, and ethylene-oxide sterilization is valuable and advantageous. It deodorizes as it sterilizes and leaves articles free of residual chemical.

Q. Can an ordinary sterilizer be "rigged" for use with ethylene oxide?

A. Sterilization with ethylene oxide requires specially constructed apparatus which controls the rate at which the gas is admitted to the sterilizer and the relative humidity essential for efficient sterilization.

Q. Are the general requirements for sterilization with ethylene oxide the same as for steam?

A. To be effective, the gas must contact all bacteria. It is unpredictable in its diffusion; hence all air must be evacuated from the sterilizer. This involves the use of 27 inches of vacuum. At a relative humidity of less than 25 percent, ethylene oxide is not germicidal. This humidity is difficult to attain unless the actual volume of the sterilizer is known.

Q. We have been told that ethylene oxide is highly combustible. Is this true?

A. Ethylene oxide is combustible in pure concentration. In sterilization practices, however, it is used in 20 percent concentration with 80 percent of carbon dioxide. In this ratio, it is noncombustible.

Q. Can you use paper wrappers in an ethylene-oxide sterilizer?

A. Any wrapper or container except hermetically sealed glass is suitable for use in these sterilizers.

Q. Is any special technic required for packaging supplies for sterilization in ethylene oxide?

A. Packaging is less critical than for steam sterilization because ethylene oxide will penetrate most of the plastics, except Kel F. and Teflon. It will penetrate paper and cloth. It will not penetrate a sealed aluminum envelope.

Q. The thermometer in the drain line of our sterilizer and the recorder are not coordinated. Which one should we go by?

A. The thermometer in the drain line is less likely to be in error than the recorder.

Q. Will we be using cobalt bombs for sterilization in the operating room?

A. A cobalt bomb is enormously heavy and expensive and requires highly technical supervision to operate. Its total sterilizing capacity is small, and it is only good for specialized instruments.

The most feasible use of atomic energy in hospitals is to hitch it to generators to make the steam for steam sterilizers. To date, atomic energy has no practical application in hospitals beyond research purposes in the experimental laboratories.

Q. Do automatic controls on a sterilizer make superheating worse?

A. Automatic controls on a sterilizer have nothing to do with superheating. The latter is determined by the condition of the textile fiber or rubber when it is placed in the sterilizer.

Q. When superheating is present, is the pressure inside the sterilizer changed?

A. Superheating does not affect the pressure inside the sterilizer. If it could develop more pressure, the energy could be contained in the same phase relationship. Superheating can only occur when no moisture is present to be converted to steam to build up pressure.

Q. Does every sterilizer need its own exhaust line?

A. No. If the exhaust line goes straight up through the roof and is of adequate size, it can accommodate four exhausts. The pipe must be at least four inches in diameter. A smaller pipe will force steam back into other sterilizers and contaminate their contents with condensate.

Q. What is wrong when water runs out of the sterilizer when the door is opened?

A. Usually it means that the air and condensate line is plugged and condensate cannot drain out until the door is opened and it can spill out.

Q. What is responsible for all the extra moisture in the front of the sterilizer?

A. There are various reasons for the front of the sterilizer being excessively wet, including a dripping vent or a cold door. If water pools in the back of the sterilizer, the reason usually is that the sterilizer is not level and condensate pools in the back instead of running out the air and condensate discharge. This is corrected by jacking up the back legs of the sterilizer so that condensate will run down and out.

Q. How can you prevent the drip from the vent?

A. The vent line should be installed properly so that the vent valve is at the highest point and runs all the way downhill to an open funnel. Condensing steam will then run away from the sterilizer.

Q. Can a sterilizer be fixed to run at both 250° F. and 270° F.?

A. Yes, but it is not a reasonable thing to do, because 270° F. is only used for emergency sterilization of instruments, and any sterilizer used for this purpose should be small and available at all times.

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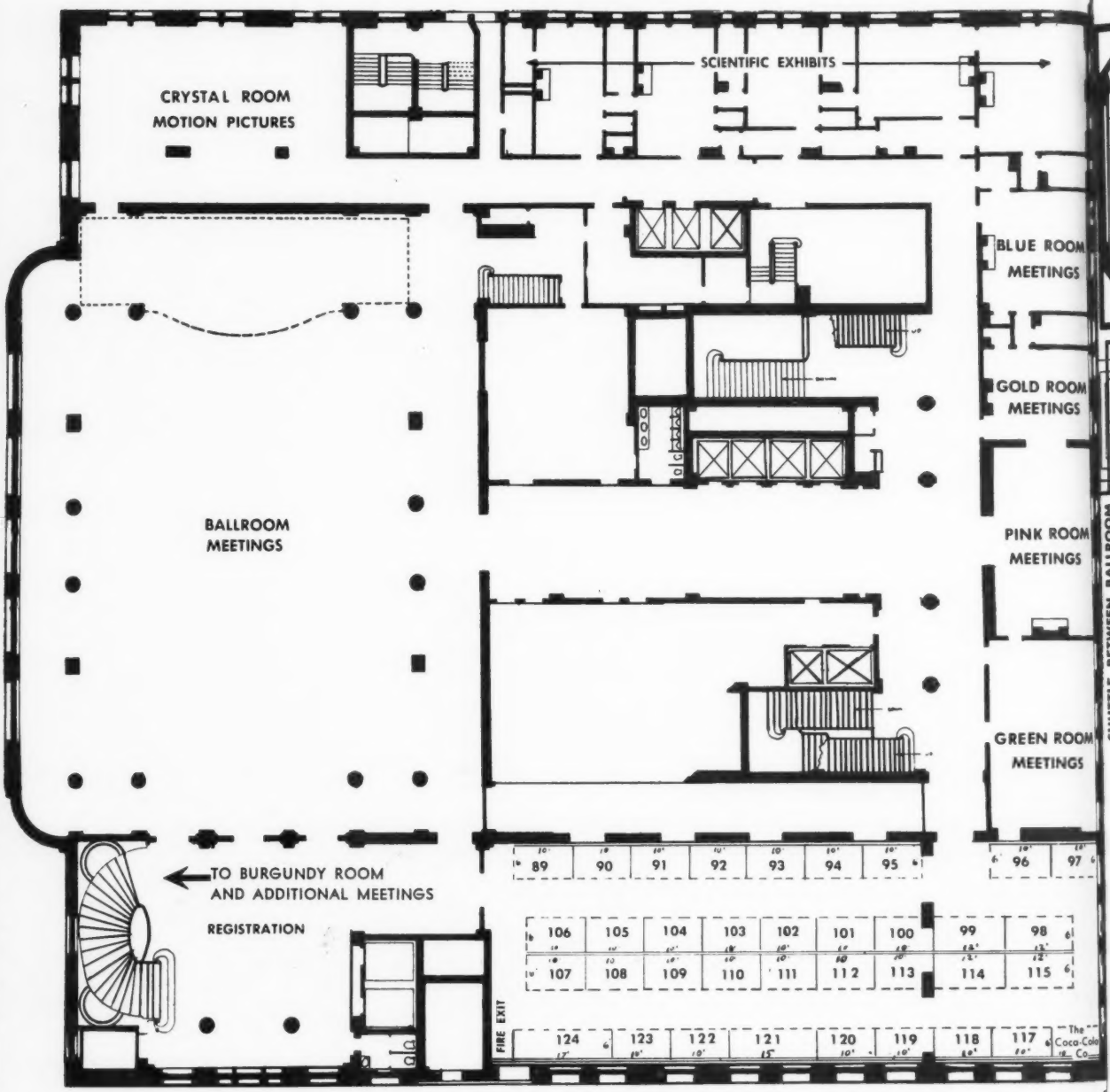
AORN Exhibit

Bellevue Stratford Hotel



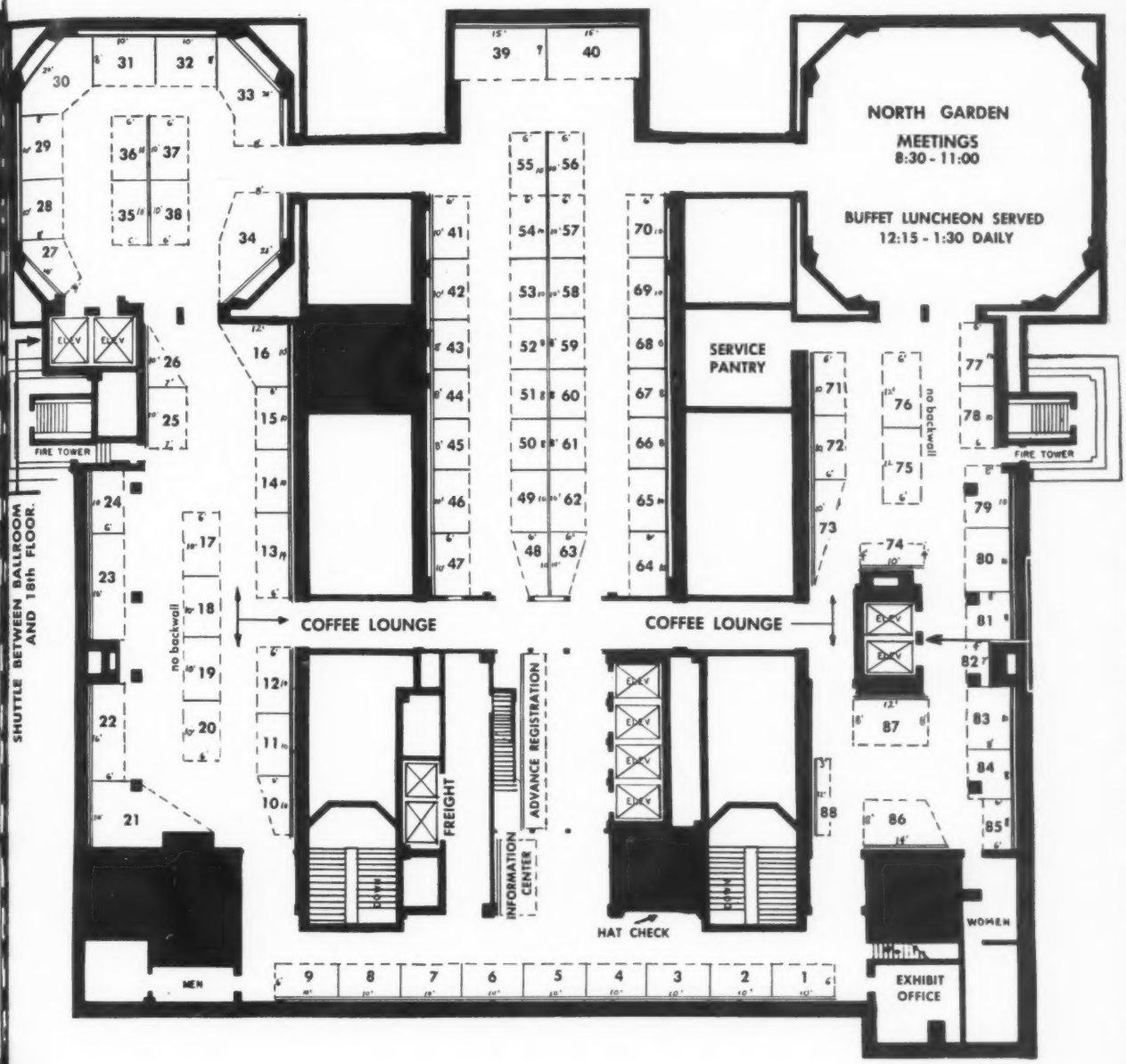
BALLROOM FLOOR

It helps you get your bearings if you have a preview of where everything is. Here is the floor plan of the fifth national congress, Association of Operating Room Nurses. Indications are that the attendance will top that of every previous year.

Because the growing AORN congress required more space than could be provided on any one floor of the Bellevue Stratford Hotel, the meetings and the technical exhibits

and Meeting Areas

Philadelphia • February 10-13, 1958



18TH FLOOR

have been divided, as equally as possible, between the Ballroom floor and the 18th floor. In addition to the regular elevators, four special cars will provide non-stop shuttle service between the two floors. These special elevators are indicated at the left of booth 26 and between booths 74 and 87.

For a preview of what the technical exhibitors will display at the congress, please turn the page.

Introducing

AORN Technical Exhibitors

These carefully selected technical exhibitors will be on hand to give you on-the-spot answers to your operation and maintenance problems, and to show you how you can utilize their operating room supplies and equipment most effectively. Well-qualified representatives will be glad to demonstrate fully any product, apparatus, or attachment. Exhibit hours will be 11 a.m. to 3 p.m. daily, Monday through Wednesday. No meetings have been planned for these hours so that you may take full advantage of this opportunity to see these products and solve your problems.

Abbott Laboratories, North Chicago, Ill. Booth 103. Exhibit will present comprehensive line of prepared intravenous solutions, Pliapak plastic blood bottles, and disposable equipment, as well as Pentothal sodium, Quelicin, and procaine products.

Acme Cotton Products Co., Inc., New York City. Booth 23. "No Tug o' War" adhesive tape that will rewind to the core, pre-wrap sterile combination pads, Acme R.T. surgeons' caps, and Scottie O.R. caps and face masks as well as a complete line of high quality dressings will be displayed.

Aeroplast Corp., Dayton, O. Booth 91. Aeroplast plastic bandages will be exhibited. Sprayed from an aerosol type container, Aeroplast rapidly forms a transparent, flexible, sterile film which does not adhere to the wound. Film "breathes," allowing escape of perspiration by vapor transmission, and withstands movement and washing.

Air-Shields, Inc., Hatboro, Pa. Booth 126. New model Jefferson ventilator with built-in volume indicating breathing bellows will be on display as well as the NonReBreathing head which will fit any model of Jefferson ventilator and will provide positive and negative pressure during nonrebreathing anesthesia or during use as respirator. Also featured will be both the portable and the mobile bedside models of the Dia-Pump compressor aspirator, designed for continuous duty operation.

A. S. Aloe Co., St. Louis, Mo. Booth 80. Exhibit will feature Alumiline, light, functional hospital furniture, completely static conductive and noncorrosive.

American Cyanamid Co., Surgical Products Division, Danbury, Conn. Booths 62, 63, 95-B. In booths 62 and 63 will be displayed the Elliptron needle, a major advance in surgical needle design, and Davis and Geck brand sutures, featuring Surgilar SP and Surgilope SP Sterile Strip-Pack, which offer complete elimination of glass jars, jar solutions and glass tubes, in a full line of absorbable and nonabsorbable needle sutures. In booth 95-B, VIM interchangeable hypodermic syringes and needles will be shown, including Gabriel vial aspirating syringe, VIM clear barrel interchangeable syringe, and a new, sterile packaged Damascus hypodermic needle.

American Cystoscope Makers, Inc., New York City. Booth 67. Representatives will demonstrate new time- and labor-saving equipment and accessories, and offer suggestions on care and maintenance of telescopic instruments.

American Hospital Supply Corp., Evanston, Ill. Booths 56, 57, 58, 59. Featured items from the complete line of hospital equipment, supplies, and specialties on display will be Tomac conductive sole shoes in several styles and colors; paper sterilizing specialties, including printed wraps and envelopes, some self-sealing; and other new surgical specialties.

American Sterilizer Co., Erie, Pa. Booths 39, 40. Exhibited will be the "ElecDraulic" surgical operating table, providing ease in raising and lowering, and the dual video light for major surgery with or without radiology or television. Choice of light intensity ranges from 1,000 to 10,000 foot candles through Variac Control.

Anchor Products, Addison, Ill. Booth 35. Stainless steel surgical needles will be displayed. Also shown will be needle cabinets, and stainless steel sterilizing boxes and holders. Representatives will be available to discuss matters of mutual interest.

Aseptic-Thermo Indicator Co., North Hollywood, Calif. Booth 43. Display will include sterilization aids, Steam-Clox and Sterilometers — indicators for proof of proper sterilization; steriLine syringe, needle and catheter sterilizing bags, and needle and catheter holders. Introduced will be nipple caps for terminal sterilization of infant formulas; paper and rubber tubing and pressure-sensitive labels, both with built-in indicator; and bag closettes.

A.S.R. Products Corp., New York City. Booth 34. SteriSharp, the stainless steel surgical blade in a sterile pack, will be displayed. Heat-sterilized in vinyl-lined foil, blade is autoclavable.

Austenal, Inc., New York City. Booth 37. The surgical division will feature "Homo Vitallium" and the latest additions to the line of Vitallium surgical appliances and Austenal instruments. Copies of "Leaves from a Nurse's Notebook" will be available.

C. R. Bard, Inc., Summit, N. J. Booths 5, 6. The new sterile pack, inflatable balloon catheter, in 5 cc. and 30 cc. sizes, will be officially introduced to hospitals at this meeting. Also displayed will be instruments and prostheses for general surgical use; nylon artery grafts; heart-lung machine catheters; bile-collection bags, and a variety of duct drains.

Bard-Parker Co., Inc., Danbury, Conn. Booth 28. B-P surgical knife handles and Rib-Back blades, Rack-Pack and the new sterile blade pack will be on display. In addition, blade forceps, the Reese dermatome, B-P formaldehyde germicide, Chlorophenyl, and the new B-P concentrate, Halimide, will be shown, as well as blade jars, instrument containers, transfer forceps.

Bauer & Black, Chicago. Booths 31, 32. Among the Curity surgical dressings and sutures exhibited will be sutures on new dispensing reels; prepack surgical dressings; safer radiopaque sponges; packs; Telfa, Kerlix, Sorbant dressings, and Gypsona and Ostic plaster bandages.

Baxter Laboratories, Inc., Morton Grove, Ill. Booths 71, 72. Exhibit will feature company's full line of products used in the operating room, including intravenous solutions and sets, blood bottles and administration equipment, and the Incert additive vial which provides maximum safety, speed, and economy for supplementing parenteral fluids.

Rudolph Beaver, Waltham, Mass. Booth 26. The Beaver replaceable blade knife will be on display with all 28 blade shapes, designed for various uses in general surgery as well as specialized technics. Also shown will be the Beaver blade file and tray pack blades.

Becton, Dickinson and Co., Rutherford, N.J. Booths 92, 93. Wilson surgeons' gloves will be highlighted as well as four new sizes of Medical Grade vinyl tubing, which can be sterilized by boiling or autoclaving, and the Multifit interchangeable control syringe.

S. Blickman, Inc., Weehawken, N.J. Booth 115. On display will be explosion-proof stainless steel operating room equipment, including instrument stands, surgeons' and anesthetists' stools, instrument tables, kick buckets, and anesthetists' tables, all fitted with conductive casters, tips or glides, and featuring seamless welded construction for maximum sanitation.

John Bunn Corp., Buffalo, N. Y. Booth 86. All necessary equipment for complete glove-processing room will be displayed. Featured will be the Bunn glove tester, with its own compressor, which enables operator to locate pinholes and weak spots in surgical gloves rapidly and accurately. Ultrasonic cleaner, which processes needles, syringes, and instruments by sound waves, will also be shown.

Wilmot Castle Co., Rochester, N. Y. Booths 94, 95 and 95A. Modern surgical and lighting equipment will be demonstrated as well as new technics in sterilization by ethylene oxide gas mixtures. Also shown will be new automatic emergency lighting for the surgery, and demonstrations will be made of new surgical technics and elements for the operating suite.

Chesebrough-Pond's, Inc., New York City. Booth 83. Prepacked, pretested, sterile "Vaseline" petrolatum gauze will be exhibited in its various sizes designed for efficiency and economy.

The Gilbert Hyde Chick Co., Oakland, Calif. Booth 87. Visitors will see live models demonstrate the Davis patient roller, DV-Combination orthopedic and surgical table and the Chick Variety Infants' cast table.

Clay-Adams, Inc., New York City. Booth 104. Ayre stomach and colon brushes for cancer diagnosis; Siliclad, a new, water-soluble silicone concentrate; Huber Lung Model, a dissectable teaching aid, and an assortment of Clay-Adams operating room specialties, including sterile Intramedic polyethylene tubing, Autoclip applier and remover, CRI germicide, and several new items will be shown.

The Coca-Cola Co., New York City. Booth 116. Ice-cold Coca-Cola will be served through the courtesy and cooperation of the Philadelphia Coca-Cola Bottling Co., and the Coca-Cola Co.

Conductive Shoe Co., West Hartford, Conn. Booth 102. Conductive Stick-ons and conductive Slip-ons will be featured. In addition, materials and products of other manufacturers used in the conductive program will be shown.

Connecticut Bandage Mills, Inc., Bridgeport, Conn. Booth 48. Among the new products featured will be Alumafoam nasal splints, which may be molded and formed to fit the individual patient's physical structure. Splints may be used full size for protection after plastic surgery or cut down to immobilize nose, following fractures, contusions or other injuries.

Cutter Laboratories, Berkeley, Calif. Booths 68, 69. Visitors may view complete blood-banking line, including blood donor and administration equipment and featuring the Saftiflex plastic blood container. Cutter intravenous solutions, administration equipment, and hospital specialty items will also be shown.

Davol Rubber Co., Providence, R. I. Booths 122, 123. Surgical products of rubber and plastic will be exhibited.

J. A. Deknatel & Son, Inc., Queen's Village, Long Island, N.Y. Booth 49. Surgical gut in the Deknatel Plastic Pak, transparent package which guards against leakage and reduces suture handling, will be displayed.

DePuy Mfg. Co., Inc., Warsaw, Ind. Booth 46. The Fenton tibia bolt, new compact hand surgery table, the Universal intertrochanteric bone plate, and many other new orthopedic products will be exhibited.

Dittmar and Penn Corp., Philadelphia. Booth 36. A variety of stainless steel self-retaining retractors for abdominal, thoracic, and general surgery will be featured. Many new instruments will be displayed.

Doho Chemical Corp., New York City. Booth 44. The Mallon Chemical Corp., subsidiary of Doho Chemical Corp., will exhibit Rectalgan, the liquid topical anesthesia for pre- and postoperative use, and Dermoplast, aerosol freon propellent spray for pain, itching, and burns.

Duke Laboratories, Inc., South Norwalk, Conn. Booth 27. Exhibit will highlight Elastoplast, stretchable, adhesive-surfaced bandages and unit dressings; Gelocast, a prepared Unnapaste bandage; Nivea Creme, Nivea oil and Basis soap for patients with dry, sensitive skin.

Eisele & Co., Nashville, Tenn. Booth 121. Full line of clinical thermometers, both regular and interchangeable hypodermic needles, Eco bandage, and specialty glassware will be shown.

(Continued on next page)

Ethicon, Inc., Somerville, N.J. booths 77, 111, 112, 113. Exhibit will feature CP surgical gut, Tru-permanized silk, and other textile sutures; Atraloc Tru-Temper needle sutures; Bio-Sorb absorbable dusting powder; Gamophen antiseptic surgical soap; tantalum gauze and other tantalum surgical materials; Sutupak, pre-cut sterile materials; surgical steel sutures and gauze; Surgiset and Pocket Surgiset, suture assortments; Ligapak, spiral wound sutures; and new ophthalmic sutures.

The Fengel Corp., New York City. Booth 75. The company will display a full line of surgical and laboratory supplies including rubber goods, glassware, surgical instruments, hypodermic needles, and syringes. Featured will be Swedish stainless steel instruments, and English noncorrosive surgical needles.

Gomco Surgical Manufacturing Corp., Buffalo, N.Y. Booth 78. Complete line of suction and pressure equipment will be exhibited, including a new mobile aspirator, which affords strong, controlled suction, for floor use where large capacity and rugged durability are needed.

B. F. Goodrich Industrial Products Co., Akron, O. Booth 3. Company will exhibit full selection of surgeons' gloves, including "Eudermic" special purpose gloves for those with contact dermatitis, and a new glove especially designed for sensitivity and comfort. Other hospital sundries will also be displayed.

Gudebrod Bros. Silk Co., Inc., New York City. Booth 74. Exhibit will display new advances in the Gudebrod line of sutures and packaging. Features include color-coding, Cerethermic finish, and Dri-Pak in sterile envelopes.

Harold Supply Corp., New York City. Booth 55. Steriphane, the completely integrated system for processing, sterilizing, and packaging needles, syringes and catheters, will be on exhibit with Sterilwraps and related central supply and operating room specialties.

Hausted Manufacturing Co., Medina, O. Booth 96. On view will be complete units for emergency room and recovery room—sliding and tilting easy-lift, standard, and economy stretchers, and Conver-table, an emergency OB table, portable examining table and stretcher, and new Invalaid chair, designed to hold patient's position at any angle from horizontal to erect. Also shown will be intermittent traction machine which compensates for movement of patient. Machine is hydraulically operated, electronically controlled.

Homer Higgs Associates, Inc., New York City. Booth 114. Exhibit will feature Dennison Sterilwraps, specially processed paper for sterilization of supplies, Faultless Epiderm and Endurance surgeons' gloves with color-banded or rolled wrists combining comfort and sensitivity with tear-resistance and economy.

Franklin C. Hollister Co. Chicago. Booth 38. The company will demonstrate and explain the recommended technic of on-the-wrist identification with Ident-A-Band. The patient's name, hospital number, and doctor's name, sealed inside Ident-A-Band, provide the O.R. nurse, surgeon, and others concerned with positive proof of identity.

Hollywood Turban Products Co., Chicago. Booth 81. On display will be Marvella nurses' surgery caps designed for ease of fit, complete hair coverage, and ventilation. Available with elastic or drawstring back, cap is made in easily laundered white cotton shirting, white nylon mesh, or white, misty, or jade green muslin.

Huntington Laboratories, Inc., Huntington, Ind. Booth 61. The company will display conductive floor waxes and floor machines and cleaners; Hexachlorophene Germa-Medica surgical soap; Hexa-Germ antiseptic skin detergent; Hi-Sine germicide; soap dis-

Meeting to discuss plans for the "Exhibitors' Night" party to be held during the fifth national congress, Association of Operating Room Nurses, were these members of the planning committee for the event: (standing, l. to r.) Owen K. Jolly, Ethicon, Inc., raising his hand in tribute to a bigger and better congress; Orville Nuffer, Mead Johnson & Co.; Felix Bronneck, Lehn & Fink, Inc., co-treasurer; Reginald Bates, J. Sklar Mfg. Co., co-treasurer; and David Housh, Surgical Products Division, American Cyanamid Co., co-chairman. Seated (l. to r.): W. M. Boucher, Johnson & Johnson, entertainment chairman; Charles B. Moore, Bard-Parker Co., Inc., chairman; and Theodore Anker, S. Blickman, Inc.

pensers; Instru-San surgical instrument cleaner; and deodorants, insecticides, and sanitation supplies.

Dr. S. Jackson, Import-Export, Washington, D.C. Booth 11. Supramid Extra, new polyfilament, synthetic suture, will be exhibited. Suture consists of several strands enclosed within a perfectly smooth cover and is extremely pliable and strong.

Johnson & Johnson, New Brunswick, N.J. Booths 107, 108. The winner of Johnson & Johnson's third annual AORN convention contest will be featured. Patient-Ready and Pre-Wrap dressings of all types, including sterile pre-wrapped, postoperative sponges will be shown. Two new nonadhering dressings are now available—Adaptic for moist technic and Steripak for dry use. Another feature will be color-cast bandages.

The Lawton Co., New York City. Booth 97. A number of new instruments will be demonstrated, including Lamb-Wedge-Lock handles for various retractors, nontraumatic clamps for intestinal surgery, and vascular clamps. The recently completed 600-page catalog will be available for inspection.

Lehn & Fink Products Corp., New York City. Booth 42. Specialists in the practical and professional aspects of enviromental asepsis will discuss control of cross-infection, suggest disinfection procedures, and provide informational material for visitors at the booth.

The Liebel-Flarsheim Co., Cincinnati, O. Booth 109. Latest electromedical-electrosurgical equipment, including the L-F BasalMeteR, the first automatic, self-calculating metabolism unit, will be displayed.

The Lin Co., Clinton, Okla. Booth 85. Display will feature explosion-proof, automatic, sterile solution warmer, for operating rooms and wards. Adjustable thermostat control keeps solution at fixed temperature indefinitely without attention from nurse.

The MacBick Co., Cambridge, Mass. Booth 66. The Pour-O-Vac System for safe, economical preparation of sterile surgical fluids will be featured. Also on display will be a new closed system for T.U.R. bladder irrigation, an explosion-proof solution-warmer, and other O.R. items.

The Maico Co., Inc., Minneapolis, Minn. Booth 10. Exhibited will be one of the electronic stethoscopes, known as the Ploss ECM. This electronic constant monitoring system consists of an electronic amplifier for auscultation, two microphone pickups for heart and blood pressure sounds, and a magnetic receiver fitted into an individual ear mold. Used during and following surgery, it allows consistent listening for detection of significant heart changes.

Marsales Co., Inc., New York City. Booth 12. Highly absorbent, soft surgical dressings and new, efficient O.R. dressings, as well as latest achievements in pre-packaging for central supply economy will be shown.

S. E. Massengill Co., Bristol, Tenn. Booth 22. Visitors are invited to stop at the booth and discuss Massengill pharmaceutical products. Featured will be Homagenets, the only homogenized vitamins in solid form; Saferon, the peptonized iron; the hematinic, Livitamin; and Massengill powder.

Mead Johnson & Co., Evansville, Ind. Booth 25. The company will be displaying many new features of the constantly closed system for blood transfusions and parenteral solution infusion, including unique inverted filter for unimpeded flow; the filter-then-pressure system for safety in rapid transfusions; and the dual drip Y-set for separate control of blood and solution flow.

Medical Fabrics Co., Paterson, N.J. Booth 29. Complete line of cotton and rubber elastic bandages, elastic adhesive dressings, and plaster of Paris bandages and splints will be shown. Featured will be the new Flex-Master rubber elastic bandage.

Meinecke & Co., Inc., New York City. Booth 101. On display will be Haemo-Sol, for cleaning surgical apparatus and instruments, and Sterilwraps, for wrapping sterile packs, as well as the Sterling hand brush dispenser.

E. Miltenberg, Inc., New York City. Booth 19. Among products on display will be the new line of Miltex stainless steel surgical needles, which combine the tensile strength of carbon steel with the corrosion resistance of fine stainless, and are available in all popular patterns and sizes. Also exhibited will be the complete line of fine quality Miltex surgical instruments, and the Erka blood-pressure apparatus.

V. Mueller & Co., Chicago. Booth 70. New instrument patterns, including diamond-jaw needle holders and R-65 scissors, will be shown, as well as a representative line of Mueller surgical pumps. Highlight of the exhibit will be a demonstration of the Duo-Trace Cardioscope. Visitors are invited to discuss instrument and surgical problems with representatives.

Ohio Chemical & Surgical Equipment Co., Madison, Wis. Booths 105, 106. High-strength, needled Tenso-Pli catgut sutures, mounted on the twin Dispenso-reel and packed in a plastic envelope, will be featured. Extra conveniences in the handling of surgical sutures will be displayed and demonstrated, and a wide variety of the surgical instruments will be exhibited.

O. R. Products Co., Newton, Mass. Booth 1. Company will display representative items from its complete line of conductive shoes and conductive strips for surgery.

Orthopedic Frame Co., Kalamazoo, Mich. Booth 47. Featured will be a new vacuum cleaner attachment developed for the Stryker Cast Cutter to eliminate dust as the cast is cut. In addition the Stryker plaster dispenser,

(Continued on next page)

Operating Room Planning Consultant

Decisions have been made at this 908 bed Medical Center to construct a new $2,000,000 surgical wing and to establish a Department of Experimental Surgery.

For at least the next two years, while physical planning is in progress, a well qualified operating room nurse will serve as a planning consultant for the new wing. During this period, she will have broad authority to recommend the functional design of each component of the surgical wing. She will also be offered ample opportunity for advancement in the long-range plans of the medical center.

Salary is open, commensurate with experience. Every applicant for this position will receive a prompt reply to her application. All inquiries will be treated in strict confidence.

Apply directly to:
MILDRED LORENTZ
Director, Department of Nursing

MICHAEL REESE HOSPITAL
MEDICAL CENTER
Chicago 16, Illinois

TIME-TRIED
Diack Controls

I'm An Operating Room Supervisor

All this year I've been besieged by salesmen with something new to prove sterilization of dressings.

I tried samples of this and I tried samples of that. Some of the sterilization controls seemed to work and some didn't. I even asked our bacteriologist to check the autoclave with cultures as they were recommended to us at one of our meetings.

After all this testing, I decided that none of the methods for proving heat penetration worked as well as the system our hospital has been using for 40 years or more. The system follows the every day use of Diacks.

So again this year, just as we always have done, we're using a Diack at the center of each bundle of dressings.

My advice to you is "try the substitutes," if you want to experiment—then you'll see why I use Diack Controls.

SMITH and UNDERWOOD
1841 N. Main St. Royal Oak, Mich.
Sole manufacturers Diack and Inform Controls

and power surgical tools will be demonstrated.

Parke, Davis & Co., Detroit. Booths 64, 65. Representatives will be available to discuss products of special interest to O.R. personnel, such as Chloromycetin intramuscular, Surital sodium, and parenteral Dilantin. Benadryl, Carbrital, penicillin S-R and S-R-D, thrombin topical, Oxycel, and surgical dressings will also be featured.

Pharmaseal Laboratories, Glendale, Calif. Booth 51. The company will exhibit a complete line of high-quality, expendable plastic intubation equipment, as well as the Pharmaseal, Sigmol, oil retention, and dry-mix enemas.

George P. Pilling and Son Co., Philadelphia. Booth 4. Entirely new Chevalier L. Jackson bronchoscopic instruments with new lighting features will be on display, as well as the new Barron food pump and the ABCO Kleen-Air-Odor tent.

Pioneer Rubber Co., Willard, O. Booth 15. Rollpruf and Quixam surgical gloves will be shown, as well as the new Pylox "Nimble Fingers," an innovation in hand protection.

Pratt Hospital Equipment Mfg. Co., Los Angeles. Booth 16. Featured will be the sturdy, adjustable recovery room stretcher with conductive mattress cover, nylon safety strap, removable head rail, all-position, retractable side rails, and lower tray for blankets and accessory storage.

Professional Tape Co., Inc., Riverside, Ill. Booth 54. Exhibit will show hospital labeling systems. Over 500 categories available to supply labels for central supply, O.R., solution room, pharmacy, and other departments. Labels, polyvinyl-coated for durability, are designed to eliminate danger of self-inoculation and prevent confusion as well as satisfy time conditions for sterilizing and other hospital procedures.

Propper Mfg. Co., Long Island City, N. Y. Booth 117. Comprehensive line of autoclave instruments will be exhibited. Featured will be Temptubes, sterilizer control tubes; Sera-Sharp, sterile disposable blood lancet; and aneroid and mercurial sphygmomanometers.

Randall Faichney Corp., Boston. Booth 50. Harvard spinal manometer unit, Quincke spinal needles with matching numbers, and special sterilizing cases for the O.R., will be featured. Also on display will be heart catheterization needles, polyvinyl tubing with thin wall needles, and complete line of precision Ranfac hypodermic needles and syringes.

Richards Mfg. Co., Memphis, Tenn. Booth 119. Company will feature the new Boyes-Parker hand operating table, designed to streamline hand-surgery procedures and to provide the surgeon and O.R. nurse with portable, convenient work stand. Also featured will be a new wrapper for autoclaving supplies, the Kane sterifabric, developed and tested by an operating-room nurse.

Ritter Co., Inc., Rochester, N. Y. Booth 60. Equipment of practical assistance to surgeons and the O.R. nursing staff will be on display for examination and discussion. Featured will be up-to-date tables for genitourinary and proctologic procedures, and the latest chair-table designed for ophthalmology, ENT, and plastic surgery uses.

Roche Laboratories, Division of Hoffmann-La Roche, Inc., Nutley, N. J. Booth 90. Three products of special interest to operating room nurses will be featured. These include: synthetic narcotic, Levo-Dromoran, for relief of severe pain; Nisentil, a rapid-acting, synthetic narcotic analgesic; and Arfonad, a rapid, short-acting vasodepressor.

Will Ross, Inc., Milwaukee. Booth 110. Exhibit will display products of particular interest to operating room supervisors. A full line of Ruby paper products, Aren lubricating jelly, and Arex surgical cleanser will be featured.

Ruby Products Co., Inc., Milwaukee. Booth 30. Packaging materials and methods, for sterile parts and supplies, will be exhibited. Special emphasis will be given suggested technics for packaging, sterilizing, storing and handling of needles, syringes, catheters, gloves, and instruments.

See full convention program on pages 101-103.

Watch for more details in next month's issue.

Richards

BOYES-PARKER HAND OPERATING TABLE

(U. S. PATENT NO. 2,609,261)

RICHARDS ADJUSTABLE SURGERY STOOL

The Richards adjustable stool is designed primarily to be used with the Boyes-Parker Hand Operating Table. Constructed of durable steel tubing, chromium plated. Three legs give stability. The stool embodies the features of an ideal seat for the hand surgeon. The saddle shaped hardwood seat is firm and comfortable, with rounded edges.

The rigid stool does not swivel; there are no casters to slide. Simple and positive up and down adjustment. By sitting on a stool that does not pivot or wobble, the surgeon can maintain an efficient, tireless posture, resting the elbows on the projecting curves of the hand table.

No. 455 SURGERY STOOL.....$55.00

The surgeon and his assistant will find a scientifically designed workbench, efficient and steady, in the Boyes-Parker Hand Operating Table. It eliminates tension and strain during operations. Relieves cramped positions of the hands, arms and shoulders. Space for forearms and elbows improve operative steadiness without tiring, and can thus cut down operating time by 20%.

Removeable stainless steel pan facilitates washing.

Light in weight, easy for nurse to quickly place in position. Adjustable legs allow fitting to any operating table level. Collapsible; requires minimum of storage space.

Pull-out instrument board places instruments in ready position for use.

Formica top; all stainless steel parts; conductive rubber ends on feet.

No. 454	**BOYES-PARKER HAND OPERATING TABLE (Complete with No. 454A Pan).....**	**$160.00**
No. 454A	**STAINLESS PAN ONLY.....**	**16.00**
No. 454B	**STAINLESS STEEL PAN WITH 1/4" DRAIN PLUG.....**	**20.00**

RICHARDS MANUFACTURING CO.
756 MADISON AVENUE
MEMPHIS, TENNESSEE

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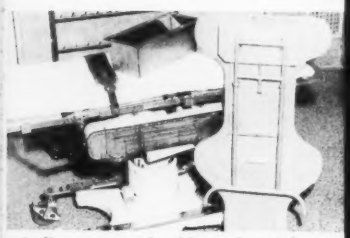
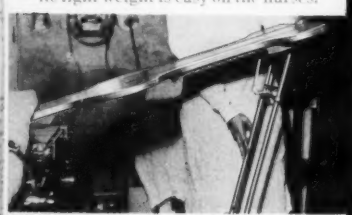
these step-by-step photographs show the Boyes-Parker Hand Operating Table in use



1. Rear view of table and stainless steel pan, folded against surgery table.

2. Nurse getting ready to set up table —its light weight is easy on the nurses.



3. Hand table being slipped under pad on surgery table—and leg being adjusted for height and stability.

4. Hand table in position—pan ready to be placed in position.

5. Pan in position for use, with central sliding leaf withdrawn.

6. Central draw leaf replaced. Small leaf withdrawn and tray of small instruments in position.

7. Sterile drape and blood pressure cuff in position—hand ready for washing.

8. Hand and forearm washed—pan removed, redraped and stockinette applied to forearm—covering blood pressure cuff.

9. Tourniquet applied from finger tips to blood pressure cuff and blood pressure cuff pumped to 300.

10. Shows table draped, and illustrates type of draftsman's stool used for stability, and low foot stool for feet. Note assistant's forearms resting on table. This makes his work restful —and permits him to always hold the injured hand steady.

11. Surgeons in position for work. A green towel beneath the operative field to cut down the glare from the lights. Also makes a good background for photography.

SOME IMPORTANT FACTS REGARDING OPERATING EFFICIENCY THE SURGEON SHOULD KNOW

- Surgery, according to the derivation of the word, is a manual art. A good artisan or craftsman, whether carpenter, jeweler, or surgeon, must first know the materials he is to deal with and then have the necessary tools and manual dexterity to use them.
- A good workman sees to it first that he has the proper place to work, and his workbench is an important factor. It must be of the proper dimensions, stable and strong, of the right height, and located so that the part worked on is held firmly, presented clearly, and is adequately lighted. The small boards usually found attached to operating tables, while suitable for holding the arm for intravenous injections, are entirely inadequate for surgery on the upper extremity.
- Industrial engineers have already determined the design for proper work spaces. From a knowledge of the average size of work spaces in the hand surgery field, the shape and size of the Boyes-Parker Hand Operating Table was scientifically determined—which enables the surgeon to work with exactness and least fatigue.
- Industrial experts have learned that the work bench height for optimum efficiency is 1″ to 3″ lower than the level of the elbows with the arms dropped at the sides. Since arm motions should be confined to the lowest classification, that is, to limit shoulder and elbow motion by resting the elbows on the table, the height of the table can be at the level of the elbow. There should be 6″ to 10″ between the top of the stool and the underside of the table to allow leg room.
- The assistant's stool is 1″ to 2″ higher than the surgeon's, other factors being equal, because the patient's hand is turned to bring the operative field at right angles to the surgeon's line of vision. He must be a little higher and lean forward slightly over the work bench.
- Variations in the length of the patients' arms are controlled by the distance which the tongue of the Boyes-Parker Hand Operating Table is placed beneath the mattress on the operating table.
- An extension tray on the arm board in which the instruments are placed makes the location of the tools constant and eliminates needless searching for tools. Instruments are at the same level and if always arranged in the same way the operator can reach out and pick up the needed tool without glancing from the field of operation. Instruments are not passed by a nurse. After use, the instrument is dropped on the table in front of the tray as the hand is reaching for the next tool. The nurse retrieves this tool or replenishes the stock from a table at her side. The stock table is not behind her, where reaching it would require a complete 180-degree turn and therefore a backward motion.
- The table has a central sliding panel which, when withdrawn, reveals an opening into which a sterile, stainless steel basin is placed for washing and irrigating the hand. The opening is large enough so that sterile drapery can be placed on the table. Scrubbing and rinsing being accomplished, the contaminated pan and drapes are removed, the panels pushed in, and sheets placed on the table, and the operation proceeds in the usual manner.

Sanders and Co., Atlanta, Ga. Booth 82. Importers of carbon and stainless steel surgical needles from England, the company will display Sanco stainless steel needles, made of especially strong alloys, and Suturcraft carbon steel needles.

Dennis R. Scanlan, Jr., Inc., St. Paul, Minn. Booth 118. The complete line of Swedish stainless steel surgical instruments, known for their quality, and design, will be exhibited.

Charles A. Schmidt Instrument Co., St. Louis. Booth 7. A full line of cystoscopic and orthopedic instruments will be displayed. The Hohm neurosurgical instrument table and a comprehensive line of Stille instruments will also be shown.

The Scholl Mfg. Co., Chicago. Booth 2. New methods of applying seamless tubular gauze dressings will be demonstrated by registered nurses. In addition, the complete Double Seal line of surgical adhesives and dressings will be shown.

The Seamless Rubber Co., New Haven, Conn. Booth 53. Kolor-Sized surgeons' gloves will be featured together with Ezon, new micro-pulverized glove powder; Pro-Cap adhesive tape, containing fatty acid salts; and the complete line of surgical dressings.

Shampaine Company, St. Louis, Mo. Booth 120. Variety and scope of complete line of O.R. equipment will be illustrated by such items as the Shampaine major operating table with head-end control for obtaining standard or unusual operative positions; instrument tables; cassette tunnel; and wide range of stainless steel operating room furniture.

J. Sklar Mfg. Co., Long Island City, N.Y. Booth 124. Exhibit will feature the latest developments in new instruments, including the Kapp-Beck serration, needle holders with T-C jaws, and the Zalkind retractors with malleable stainless steel blades on Sklar-Grip handles. Visitors are invited to view and register for recently released 15th edition of catalog and to discuss instrument problems and needs.

Smith & Underwood, Royal Oak, Mich. Booth 89. Standard Diack controls, the well-known method of determining every-day condition of autoclaves, will be exhibited. Free souvenirs will be given out at booth.

Snowden-Pencer Corp., Los Gatos, Calif. Booth 45. On display will be surgical Instrument-Milk, the new, non-oily, non-sticky, rust-prohibiting lubricant for all surgical instruments; and complete display of Ochsner Diamond-Jaw needle holders and Diamond-Edge scissors with gold-plated ring handles for immediate indentification.

E. R. Squibb & Sons, New York City. Booths 8, 9. Company will present up-to-date information on development of new therapeutic agents for prevention and treatment of disease. Results of research will be available in new products or improvements in products already marketed.

Stanley Supply Co., New York City. Booth 73. Stanvelopes, the new procedure for CSR sundry item sterilization, needle and syringe protectors for use with Stanvelopes, and Stanley Royal surgeons' needles will be on display.

Storz Instrument Co., St. Louis, Mo. Booth 100. Display of fine surgical instruments will be featured, and information on their sterilization and care will be available. Representative will answer any questions concerning maintenance or draping of equipment used in eye, ear, nose, throat, and plastic surgery, specifically the Jordan-Day bone engine and the Lempert surgical microscope. Copies of latest publications will be on display.

The Torrington Co., Torrington, Conn. Booth 14. Company will exhibit its line of stainless steel surgeons' needles, with special waterproof packaging. Eye-type surgeons' needles in wide variety of styles and sizes, scientifically treated to produce uniform temper, will be featured.

United Surgical Supplies Co., Port Chester, N.Y. Booth 79. On display will be O.R. specialties, including foundation wire and nylon mesh for support of tissue, stainless stranded sutures and many instruments used in cancer surgery. A free sample of the new stoma and drainage bag will be given to visitors.

Vestal, Inc., St. Louis. Booth 99. The prevention of staphylococcal infection among hospital patients through use of Vestal products will be described at booth. Products featured will be Septisol antiseptic soap, Staphene germicide-disinfectant, and Ves-Phene germicidal-detergent.

Edward Weck And Co., Inc., Brooklyn, N.Y. Booth 13. New dissecting scissors and new functioning needle holders, as well as Weck color change autoclave ink and new type syringe and needle racks, will be on display.

Winthrop Laboratories, Inc., New York City. Booth 41. On exhibit will be Novocain, now available in ceramic neutraglas color-break ampuls, which provide ready-to-use sterile solution without filing, scoring, or sawing. Multiple-dose vials with dual purpose caps, which permit withdrawal by needle and pouring, will also be exhibited.

The Max Wocher & Son Co., Cincinnati, O. Booth 52. The company will exhibit its complete line of surgical instruments of both imported and domestic makes, together with some new specialties.

Zimmer Mfg. Co., Warsaw, Ind. Booth 98. The company will exhibit its latest appliances and equipment for the treatment of fractures. Literature concerning the latest technics will also be available.

BY POPULAR DEMAND
2nd Printing!

SURGICAL INSTRUMENT GUIDE for NURSES

Compiled by EDITH DEE HALL, R.N.

Miss Hall's many years as an Operating Room Supervisor and Executive Secretary of the AORN have amply qualified her for preparing this clear, concise guide for OR nurses everywhere.

More than 1000 surgical instruments are illustrated, including the types of instruments required for the 250 operations defined. Its thorough coverage makes this book practically a "who's who" of surgical instruments, and an invaluable reference, not only for OR nurses, but student and teaching nurses as well. $4.50 per copy. Discounts on quantity orders of 10 or more.

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Liston Named Editor of *Today's Health*

James Liston, former special features editor, *Better Homes and Gardens*, has been named chief editor, *Today's Health*, published by the American Medical Association.

Mr. Liston will succeed W. W. Bauer, M.D., who has been chief editor since 1949 in addition to being director, AMA Bureau of Health Education.

The appointment of a full-time editor is the first in a series of proposed organizational changes, according to William Hetherington, managing publisher, *Today's Health*.

Muscular Dystrophy Clinic for Children Opens in Toledo Area

A clinic for treatment of muscular dystrophy and related diseases has been established at Opportunity Home for crippled children, Toledo, O. The new unit, the first in that area, was scheduled to open in October.

Plans for opening were announced jointly by Gerald P. Openlander, president, Toledo Society for Crippled Children, and Mrs. Robert L. Floyd, president, Lucas County chapter, Muscular Dystrophy Association of America.

John C. Van Metre, administrator, described the clinic as one of the first steps in a program to convert Opportunity Home into a full-fledged hospital for the treatment of acute diseases in children.

The new clinic will operate under direction of the medical staff of the home, and the medical advisory board of the local muscular dystrophy chapter.

Emphasis in the new clinic will be on treatment, according to Richard Baer, M.D., medical director. Patients will be referred to the clinic by their family physicians. A physical evaluation and determination of therapy necessary will be made and a report sent to the referring doctor.

Most of the necessary physical and occupational therapy can be carried out in the patient's home. In more severe cases, the children will come to the clinic as outpatients.

The patient's family will be asked to pay the nominal charges for evaluation and treatment, if they can. If necessary, the cost may be divided between the parents and the Lucas County chapter of the Muscular Dystrophy Association. When the parents cannot afford to pay any of the evaluation and treatment cost, the chapter will pay the entire amount. The chapter will also furnish wheelchairs and appliances when necessary.

Health Insurance to Cover 123 Million Persons

By the end of 1957, 123,000,000 persons in the United States will be protected by some form of health insurance, the Health Insurance Institute has estimated. This figure represents nearly 75 percent of the civilian population.

Of this group, about 109,000,000 will be covered also for surgical expenses, 74,000,000 will have regular medical expense policies, and 13,000,000 will be insured against major medical expense. Forty-three million will be protected against loss of income through illness. The largest growth in type of coverage in recent years has been in major medical expense insurance.

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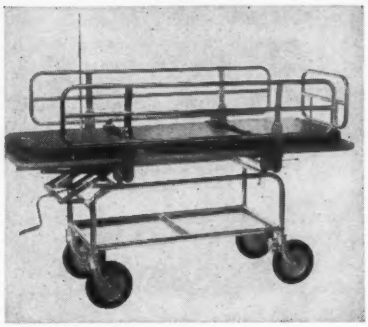
5 to 6 inches more space available for the patient when using these rails with the conventional size mattress.



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no nicked sutures . . . no glass slivers . . . no punctured gloves . . . nonirritating jar solution — all important contributions to better patient care.

saves suture strength . . . flexibility[1]

no kinks or weak spots from tight reel winding . . . eliminates excessive handling . . . nurse opens sterile sutures as needed to prevent drying out . . . needle points and cutting edges are better protected.

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far fewer sutures damaged or opened unnecessarily . . . 30% less glove damage . . . takes half the storage space . . . initial cost, no more than tubes!

1. Alexander, Edythe L.: Mod. Hosp., May, 1957

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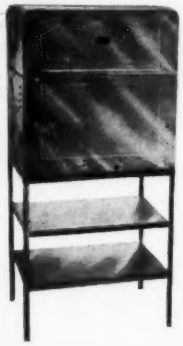

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MacBick offers a complete line of adjustable shelf and fixed shelf CSR utility trucks, flask drain trucks, portable kit tables, custom designed work stations, counterwork and storage shelving.

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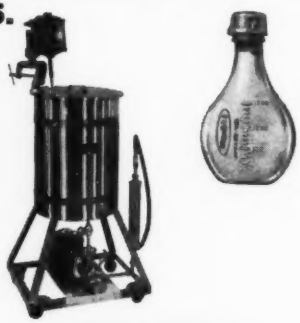

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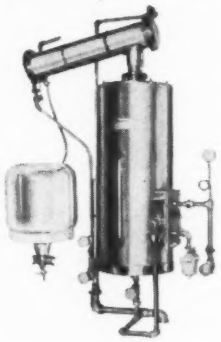

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Four Key Steps Provide Basis Of Effective Orientation Program

By Helen Rakov, R.N.*

● Prerequisite to orientation in any field of work is the careful selection of workers. Though usually this is capably done by personnel management, it is recommended, in view of the lack of a personnel department in many hospitals, that attention be focused on some of the many important considerations that singularly apply to central service workers.

Because of the physical demands of the varied tasks, it is not only necessary that trainees be of good character and morally reliable, but that they be screened to eliminate those having any physical deficiencies that may hamper job performance.

A few of these are: dermatitis, which may be aggravated by use of detergents and work in the wet area; shortness in stature, which may prevent able and comfortable reaching, piling, and stacking of packs; frailness in health and physique, which may in short time make the daily lifting tasks unendurable; and excessive weight or leg and foot conditions, which could make lengthy periods of standing painfully unbearable.

Marked attention to these and other seemingly small details can lessen costly, forced turnover in personnel, disruption of assignment schedules, and retardation of work flow.

When qualified personnel have been obtained, a program designed to achieve orientation can be initiated. A brief definition of the aim of orientation is to prepare and train one to perform the total job ably and efficiently. To aid in achieving this goal, the following key suggestions are offered:

1. Fashion an attitude of enthusiasm and respect for central service and its work.

2. Explain the necessity for each task in a manner so enthusiastic that it spurs diligent and conscientious effort.

3. Develop intra- and interdepartmental cooperation to help maintain a steady work flow.

4. Train all personnel in all tasks, to provide depth at any given job.

1. To avoid the possibility that workers may view central service tasks as menial and lacking in dignity, it is advisable to fashion an attitude of respect and enthusiasm for the department and its work. Though many ideas and methods may be employed in seeking to reach this goal, a most essential one is to explain fully and stress the high place of central service in present-day hospital organization, particularly its function as a supply line to every station, department, and attending doctor, and, more dramatically, as a lifeline to every patient.

The means of effectively communicating this point may vary from likening central service to a huge octopus whose many arms reach out into every room, station, and department through the processed needle, syringe, tray, and pack, to giving employees an actual tour of the hospital and pointing out the great importance of the work of central service.

With an initial understanding of the far-reaching scope and urgent necessity for such work, possible preconceived notions of the lowliness of the tasks are overcome, and the central-service job becomes one of dignity that sparks enthusiasm.

2. It is obvious from the very nature of central service that its tasks must be discharged with diligence and conscientiousness. Though there may be many ways to attain these ends, a very effective one is to explain clearly the reason for each job.

For example, sterilization, to some people, is just another word; to others it suggests physical operations such as boiling water and using heat or pressurizing steam. Few lay people know the basic principles and aims of sterilization; they are hardly aware of its prime necessity and the limitations of each method; they are little informed about the danger of lack of sterilization and its possible serious consequences.

However, after they hear explanations of sterilization and proper use of its various methods, of the danger of rapidly multiplying bacteria and spore formation and the urgency of utter destruction of these organisms, conscience becomes an invisible but effective spur to diligence.

To further induce conscientious and diligent work, tasks might be translated into terms of human comfort and discomfort. The tendency of workers to view their tasks as always being beneficial is good, providing the work is well done.

Why not make them aware of the discomfort occasioned by a poorly sharpened needle, the anxiety caused by an inoperative piece of equipment, or the infection and possible death resulting from lack of sterilization? By stressing these possibilities we help evolve within each worker a constant prod — conscience — the super-supervisor.

3. The principal function of central service is to supply all stations and departments with adequate amounts of properly processed supplies and equipment. This can best be assured by developing intra- and interdepartmental cooperation so that an unhampered flow of work prevails.

The intradepartmental phase can be implemented by the exemplary conduct of professional and previously established personnel. Their example sets the pattern for what is desirable or undesirable: soft tones, pleasantly spoken words instead of harsh loud ones, requests instead of orders, and kindness instead of curtness. Gossip and controversial subjects should be avoided to prevent development of areas of friction.

(Continued on next page)

*Central service supervisor, Abbott Hospital, Minneapolis.

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Interdepartmental cooperation is vital, because no central service department is sufficient unto itself. Regardless of how good a job it is doing, its total job, because of its very requirements, can only be fulfilled with the aid of personnel from all stations and departments it serves. Just as central service feeds these with supplies and equipment, they, in turn, feed back utensils, reusable supplies, trays, and equipment.

Cooperating departments reduce the central service work load by careful, less wasteful use of supplies and equipment and prompt return of scarce items, especially during peak census periods. Central service personnel can encourage such interdepartmental cooperation by giving attentive response to requests and requirements of all other stations and departments.

4. Quite often, as a result of unforeseen circumstances, such as personal problems, illness, or inexcusable absenteeism, departmental production may become dangerously curtailed. To offset the inroad on production that such eventualities may create and to lessen pressure on those at work, it is advisable to train all personnel in all central service tasks.

This practice provides greater depth in workers at any given task and enables the department head, by shifting jobs, to process in ample quantity, supplies about to become exhausted. Such training may be realized by rotating all work regularly or by scheduling weekly assignments that embrace all tasks.

Besides helping to avoid monotony and disinterest which may cause carelessness, this practice assures continuous experience in all types of work; greater productivity, because no worker is idle because of expertness in a limited number of tasks; and a flexibility that enables central service to cope with any extraordinary demand for certain supplies and equipment. Best of all, it bolsters the primary aim to prevent serious impairment of production caused by shorthandedness.

It is fully appreciated that central service orientation presents many problems not touched upon here, some general and others peculiar to the individual hospital. The four suggestions made above have general application and are submitted in the spirit of sharing observations and conclusions derived from practice and experience, in the hope that they may prove helpful to those interested in central service orientation.

Visual Aids Reduce Instruction Period, Save Time on Floors

By Edith B. Marshall, R.N.*

● To maintain the necessary high efficiency in the central supply room—a vital department in the hospital—we at the Elizabeth (N.J.) General Hospital have developed the use of visual aids for the teaching of all personnel, including registered and practical nurses, professional and practical nursing students, aides, and volunteers who work in this department.

We are using a loose-leaf notebook containing instruction sheets and photographs (see accompanying illustrations for examples).

The Hospital Pictures Service, Red Bank, N.J., which takes our baby pictures, also took the pictures for our central supply procedure book. We have found that the use of visual aids, plus the printed lists of articles needed for each procedure, has reduced the amount of instruction time needed for each member of the central supply room staff.

Central-supply personnel assemble all trays by referring to the lists in their procedure books and the appropriate photographs. In this way the person making up the tray can check the completed tray with both list and picture and see immediately whether there are any omissions or duplications.

We have an active procedure committee, consisting of a faculty member from the school of nursing, an assistant director from nursing service, a head nurse, a general staff nurse, and a student professional nurse. The committee meets each month to discuss procedures and suggested amendments.

Every three months at the head nurses' meeting, a list of breakages and losses, with cost, is given to each head nurse. This list is compiled by

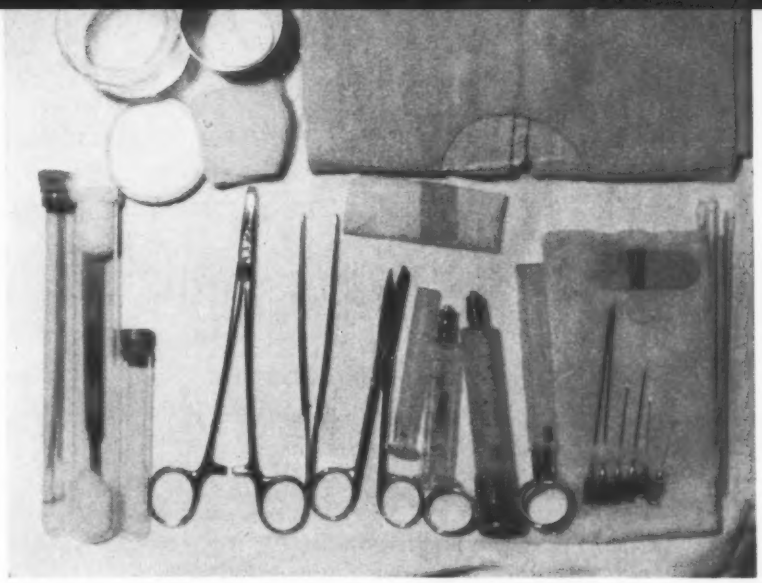
*Director of nursing service, Elizabeth (N. J.) General Hospital and Dispensary.

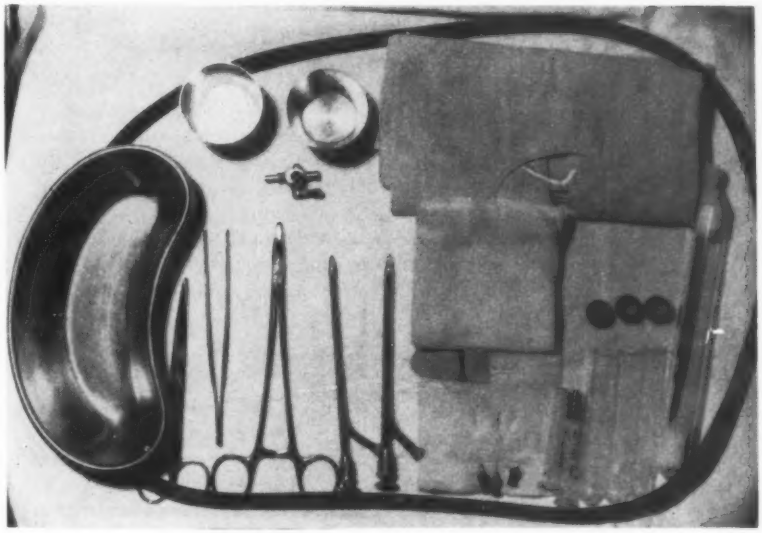
central supply and is posted on the bulletin board of each floor, thus enabling the head nurse of each department to compare her loss and breakage with those of the other floors. This list is an incentive to reduce the losses and breakages for the next three months.

The international sales department of Becton, Dickinson and Co., Rutherford, N.J., uses our central supply department for educational purposes. Before going into the foreign fields, representatives of this firm spend from several days to a week in this department learning all the procedures. This on-the-job observation has been valuable not only to these representatives but to us, for we have been given some new and better ideas on how to improve our services.

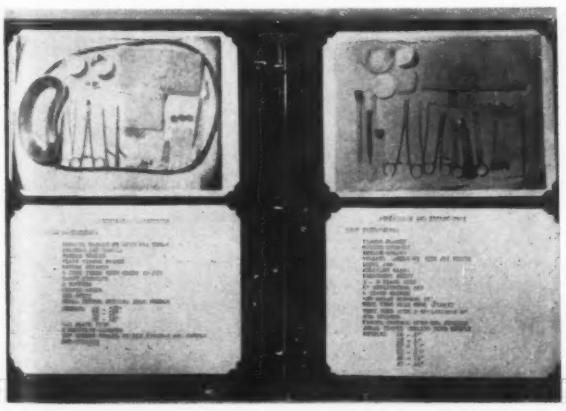
We have found that the use of visual aids in central supply has saved hours of work for our supervisor, Mrs. Theresa Mulligan, R.N. The personnel, by using the procedure book and photographs, are able to distinguish the various types of instruments and other items without constant reference to the supervisor. Then too, personnel learn the names of the different instruments more readily by comparing them with the photographs and printed lists.

Moreover, as all the trays are assembled in the same manner (i.e., by the use of the procedure book), there is less confusion on the floors for the doctors and nurses using the trays. They now know exactly where to find the equipment on each set-up. In view of the frequency of staff turnover, the consequent saving is important.





Above, top: Photograph of tray assembled with aspiration biopsy set, plus printed list of articles needed provides efficient guide for central supply staff. Above, second: Photograph showing paracentesis set. Right: Sample breakage list, similar to those distributed to each department's head nurse. Below: Looseleaf notebook, each page enclosed in transparent protective envelope.



The Elizabeth General Hospital and Dispensary

MEMORANDUM TO: MALE SURGICAL

The following is a list of the breakage and loss in your department for items sent to you from central supply for period beginning April, May, and June, 1956:

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BREAKAGE:	2	2cc. syringes	$2.25	$4.50
	7	5cc. syringes	3.00	21.00
	1	30cc. syringe	5.20	5.20
	1	2oz. Asepto	1.73	1.73
	3	1oz. Asepto	1.55	4.65
LOSS:	3	Instrument sets	23.61	70.83
	23	2cc. syringes	2.25	51.75
	35	5cc. syringes	3.00	105.00
	6	Insulin	2.25	13.50
	1	Kelly	4.81	4.81
		TOTAL		$282.97

Signed.....

Director

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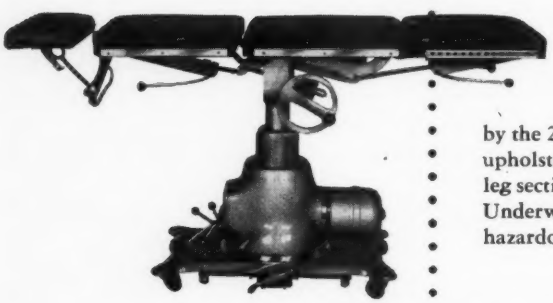

Ritter ENT and Emergency Surgery Table, 9-S-21

A touch of the toe smoothly raises or lowers this table . . . its 4-section top is quickly and easily adjustable to the positions required. Maximum patient accessibility is offered by the 20-inch top width. Table is equipped with static conductive upholstery, mobile base and floor lock, side rails on back, seat and leg sections. The exclusive Ritter motor-hydraulic base is approved by Underwriters' Laboratories, Inc., and C.S.A. for use in hazardous locations, Class 1, Group C.

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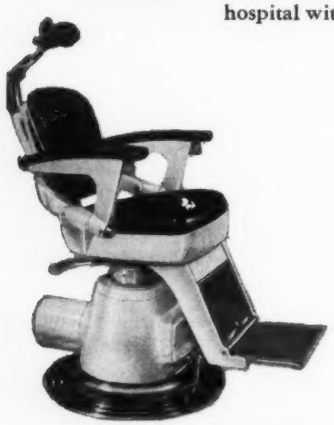
All five essentials for ENT work are within easy reach . . . air, water, vacuum, electricity and waste. Major low voltage instruments, spray bottles and medicaments are conveniently located for increased efficiency. Swinging instrument table, including special spray and suction bottle, is moved into the physician's working area by a mere touch of the fingers. Your choice of a Ritter ENT Unit provides your hospital with complete facilities for thorough examination and treatment.



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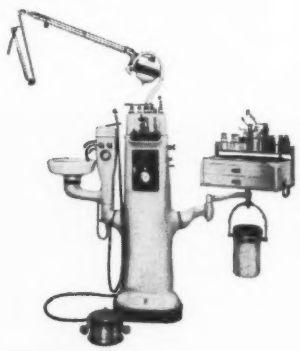

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Tips on Getting to Sleep

Sleeplessness is often caused by anxiety, according to Donald A. Laird, Ph.D., industrial psychologist, Lebanon, Ind.

Developing a feeling of security even temporarily, helps overcome worry, he said, in the August issue of *Today's Health*.

Dr. Laird pointed out that the security needed for sleep is the emotional kind, that is, the feeling of being accepted by others, rather than security from worry about the house burning down or finances. Physical contact can provide assurance, he said, and thus help overcome sleeplessness. Some people unconsciously provide their own body contact by keeping a hand on their leg, stomach, or face.

Children from three to five often go through a period of stress, and are comforted by a doll or toy animal. If a parent lies down beside them or keeps a hand on them they may go to sleep more easily.

Having a dim light in the room helps many people. Going through the same bedtime routine nightly seems to ease anxieties since the mind is temporarily distracted, Dr. Laird said.

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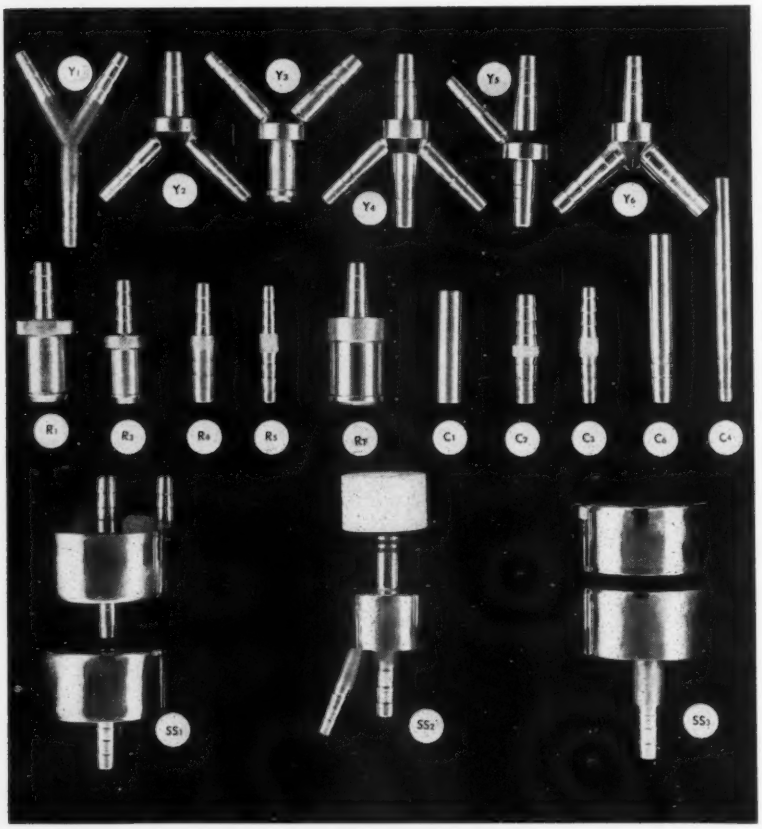

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WRITE FOR DETAILED CATALOG

Atomic Medicine Utilized In Research by VA Hospitals

Fifty-one VA hospitals are carrying out approximately 600 studies in a nationwide radioisotope program investigating cancer, heart conditions, mental diseases and hardening of the arteries.

The VA Hospital, Boston, is studying resistance to leukemia, and how the disease is transmitted.

VA Hospital, Hines, Ill., is investigating effects of hormone treatment in heart attack patients, the role of fat in hardening of the arteries, new devices to locate brain tumors, and implantation of radioactive phosphorus at sites from which brain tumors have been removed.

By tagging substances with radioactive phosphorus, researchers at VA Hospital, Sepulveda, Calif., are tracing compounds through complex chemical and biological changes in the body for clues to the origin of mental disease.

Other VA hospitals are employing radioisotopes in research on rheumatoid arthritis and on diffusion of snake venom. Radioactive phosphorus is being used in testing success of skin grafts at the Ann Arbor, Mich., VA Hospital.

Three VA Area Medical Offices To Be Relocated

The VA has announced plans to move three of its area medical offices to different localities to provide more efficient administration.

The Columbus, O., office will be relocated in Indianapolis, and the St. Paul, Minn., office will move to Omaha, as soon as feasible.

Plans are under way for the St. Louis office to move to Dallas, Tex., but no date has been set.

Each office employs approximately 28 persons, who supervise VA medical programs in multi-state areas.

Jurisdiction for Michigan's upper peninsula, Wisconsin and Illinois will be transferred from the St. Paul area medical office to the new Indianapolis office. Jurisdiction for Kansas will be transferred to Omaha from St. Louis.

After the Dallas area medical office is established, jurisdiction for Missouri will be transferred to the Omaha office. The realignment is expected to equalize the work load among the area medical offices. Remaining VA offices, located in Boston, Trenton, N.J., Atlanta, and San Francisco will not be affected.

Antibiotics Have Made Pneumonia a Minor Illness

Today's pneumonia patient is bedfast only 48-72 hours, as contrasted to weeks in bed in a critical condition, 20 years ago.

Antibiotics have made pneumonia a relatively minor ailment, Lt. Col. Philip G. Keil, M.D., Lackland Air Force Hospital, San Antonio, Tex., pointed out at a recent meeting on infectious diseases.

Pus drainage tube scars are seldom seen today in teen-agers, Dr. Keil said, and noted that diagnostic chest x-rays have also aided treatment.

Penicillin, which disrupts the chemistry of the invading organism, is the most widely used antibiotic for pneumonia. Other antibiotics, however, are highly effective in persons allergic to penicillin, he added.

Many cases are treated with home remedies, or left untreated. Staphylococcal pneumonia can quickly cause lung collapse, and these cases often have a high fatality rate.

Although antibiotics can cause serious complications, disadvantages are outweighed by beneficial effects in treatment of respiratory tract infections, Dr. Keil emphasized.

Older People Need More Light Measurement Tests Show

Persons over 60 need about twice as much light for a given task as persons between 17 and 20, according to a recent report in *Sight-Saving Review*.

The test used called for the reading of ten words in 6-point type, which were presented one at a time at different degrees of illumination. It was found that a steady increase in illumination was required with increasing age, becoming marked at age 45.

High Body Temperature Difficult to Explain

Despite "fantastic medical progress," the cause of fever still remains unsolved, according to Harrison C. Flippin, M.D., professor of clinical microbiology, University of Pennsylvania Graduate School of Medicine, Philadelphia.

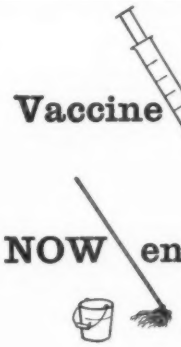
He pointed out to physicians attending a recent symposium on infectious diseases, held in Kansas City, Mo., that although body temperature is primarily controlled by thermo-regulating centers in the brain, little is known about the source and nature of fever-causing stimuli that reach these centers.

Many febrile diseases have one common factor, tissue injury. Fever may thus be regarded as a reaction to injury, Dr. Flippin said. He pointed out that tissue damage can include infections, cirrhosis of the liver, gout, neoplastic diseases, vascular accidents, and other ailments. High body temperature may also be associated with pregnancy, food intake, excessive fatigue, and psychic disturbances.

Most fevers of undetermined origin can be traced to a common disease, present in an unusual or atypical form. Fevers of less than two weeks' duration are often caused by a virus, while those of longer duration are most often caused by infections, such as tuberculosis, rheumatic ailments, and similar disorders.

Hospital Called Hazard Changes Its Name

The Dr. Hazard Memorial Hospital, Long Branch, N.J., founded in 1920 by the late Elmer C. Hazard, M.D., has changed its name to Doctors Memorial Hospital, because the word hazard is "psychologically bad." Prospective patients became apprehensive when physicians suggested they go to the institution, Walter Cohen, president of the hospital's board of trustees, explained.



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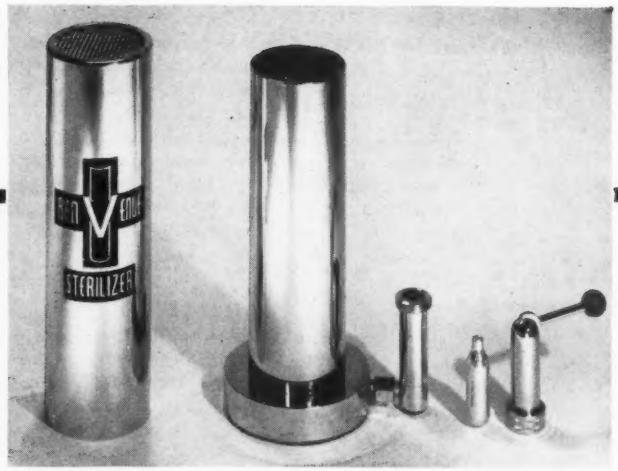

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NEW OFFICERS

The West Virginia Association for Mental Health has elected **Roy A. Cunningham,** Beckley, president. Other officers are: **Rev. Charles F. Crist,** Ravenswood, vice-president; **Mrs. Roy L. Herndon,** Beckley, secretary, and **Mrs. Jack Rhudy,** Charleston, treasurer.

DEATHS

Nellie P. Havill—62, died September 27. She had been supervisor, Hillcrest Tubercular Hospital, Vincennes, Ind.

Rudolph Matas, M.D.—97, pioneer in vascular surgery and professor emeritus, general and clinical surgery, Tulane University School of Medicine, died in New Orleans September 23. He was chief of surgery, Touro Infirmary, New Orleans, for 30 years and initiated the surgical technic, named for him, for treatment of vascular enlargements.

Frank O. Nagle, M.D.—73, professor emeritus of ophthalmology, Hahnemann Medical College, Philadelphia, died September 9. He maintained a private practice of ophthalmology until his retirement in 1953, and also served as consultant in ophthalmology for several hospitals.

Timothy Riordan, M.D.—62, chief attending dermatologist, St. Vincent's Hospital, New York, died September 17. He was professor of dermatology, New York University-Bellevue Medical Center, and chairman, dermatology section, New York Academy of Medicine.

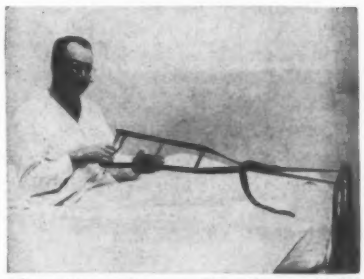
Ferris N. Smith, M.D.—73, plastic surgeon and well-known author, died September 18. A former governor, American College of Surgeons, he was one of the Founder's Group, American Board of Plastic Surgery.

Pharmaceutical Society Elects New Slate of Officers

The American Society of Hospital Pharmacists has elected the following officers for the 1958-1959 term: Robert C. Bogash, New York City, president-elect; Clinton J. Latiolais, Ann Arbor, Mich., vice-president-elect.

The present officers, who will continue their functions until the Society's annual meeting in April, are: Leo Godley, Kalamazoo, Mich., president; Charles Barnett, Jacksonville, Fla., vice-president; Gloria Francke, Ann Arbor, Mich., secretary, and Sister Mary Berenice, St. Louis, treasurer.

For Patient Protection



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Trichinosis Is Still a Threat, Veterinarian Advises

Eradication of trichinosis in humans can only be accomplished by abolishing the feeding of raw or poorly cooked garbage to pigs. Forty-three states prohibit this practice but trichinosis is still a threat, warns William C. Carter, D.V.M., Public Health Service, New Jersey.

The parasite causing trichinosis will be killed if unfrozen pork and pork products are cooked at 300° to 350°, allowing 50 minutes of cooking per pound, according to Dr. Carter. For frozen or partially frozen pork, 75 minutes per pound must be allowed. If a meat thermometer is used, it should register 185°F. at the center of the pork.

Pork which looks pink should not be eaten, and pork or sausage meat should never be eaten raw, even to sample seasoning, Dr. Carter advises.

Trustee Relationship Discussed At Mississippi Meeting

Trustee relationship—an administrative requirement, was discussed by Robert A. Ivy, administrator, Doster Hospital and Clinic, Columbus, Miss., at the meeting of the Mississippi Hospital Association, held October 9 to 11 in Biloxi, Miss. S. B. Wise, board of trustees, Coahoma County Hospital, Clarksdale; B. G. Horton, administrator, Tippah County Hospital, Ripley; Marx Huff, board of trustees, S. E. Lackey Memorial Hospital, Forest; and M. B. Rowan, administrator, Pontotoc Community Hospital, Pontotoc, participated in the discussion.

Mississippi hospital personnel had the opportunity of inspecting the new 300-bed hospital at Kessler Field, during the meeting. They also saw an air-evacuation hospital unit on flight line.

Work Simplification Featured At Vermont Hospital Conclave

Robert C. Terrill, assistant administrator, Mary Fletcher Hospital, Burlington, Vt., was chairman of a session on work simplification during the Vermont Hospital Association meeting in Rutland, Vt., on October 18. Edward Mattos, assistant director, Massachusetts General Hospital, Boston, was the speaker on the subject. The panel, all of Mary Fletcher Hospital, consisted of: Dorothy Stead, chief dietitian; Charles G. Davis, Jr., administrative assistant; and Mrs. Paul Grimm, dietitian.

Catastrophes Raise Death Toll In First Half of 1957

Catastrophes, accidents in which five or more persons are killed, took approximately 1,200 lives in the United States during the first half of this year, Metropolitan Life Insurance Co. statisticians report.

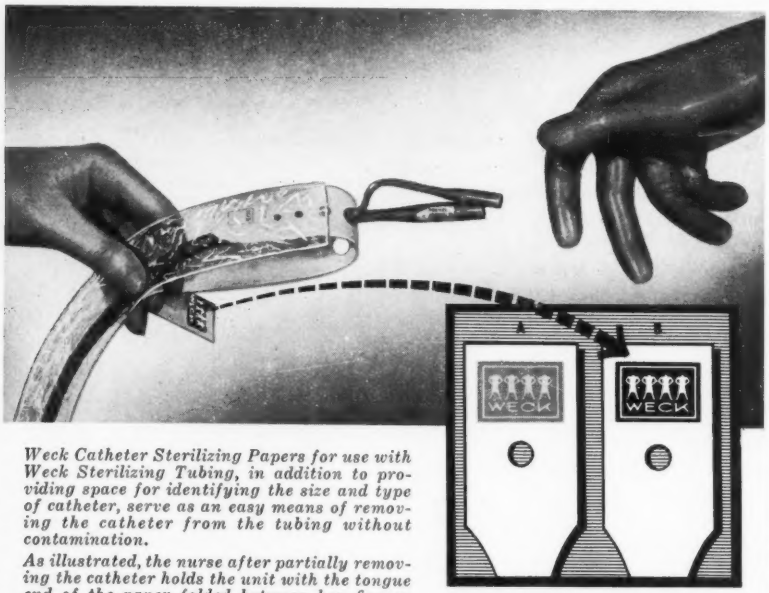
The number of lives lost was higher than for the corresponding period of any year since 1947. A heavy loss of life occurred in the Louisiana and eastern Texas hurricane, leaving 350 known dead.

Other factors contributing to the higher toll were increases in mortality from motor vehicle accidents in which five or more were killed, and greater loss of life in fires.

Civil and military aviation fatalities were much lower than in the first half of 1956, however.

Four other disasters took more than 25 lives each. Two of the four were natural disasters—the May tornado in Kansas City and a March blizzard in the Great Plains states, which killed 39 and 29 persons, respectively.

The earliest disaster of the year, a gas explosion in a coal mine near Bishop, Va., on February 4, killed 37.



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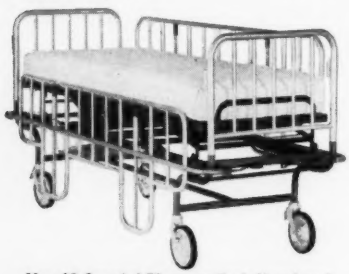

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Each of these beds comes equipped with an IV rod, which is stored under the head section of the spring. There are six different locations for the use of the IV rod.

Procedure Manual No. 2, by Alice L. Price, R.N., M.A., author of "The Art, Science and Spirit of Nursing," explains in detail the many different uses of the Hill-Rom Special Therapy—Labor-Recovery Bed, how to use and care for the bed, etc. Copies for student nurses and graduate nurse staff will be sent on request.

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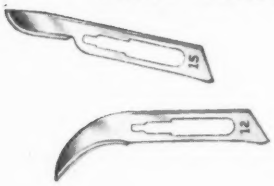

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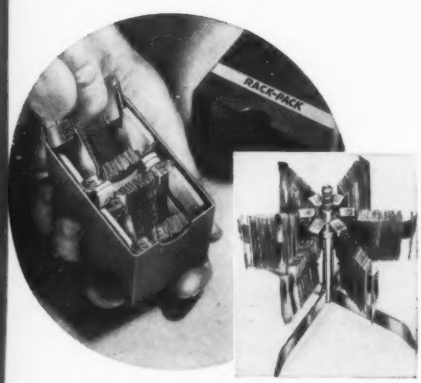

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Danbury **Connecticut, U.S.A.**

in the hospital the diuretic must work

If the first diuretic used in the patient hospitalized for heart failure is ineffective, it may be too late to try another. For this reason and many others, physicians prefer the dependability of injected MERCUHYDRIN.®

Experience with innumerable patients in several decades of use confirms the uniformly rapid response to MERCUHYDRIN with a minimum of side effects. This assured action saves lives, saves time, saves money. And when recovery is well underway, switching to oral NEOHYDRIN® has the further advantages of saving injections for the patient and time for your nursing staff.

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A STANDARD FOR INITIAL CONTROL OF SEVERE FAILURE

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